

MAVAL AVIATION SAFETY CENTER

SUPPLEMENTARY (Card No. 2)

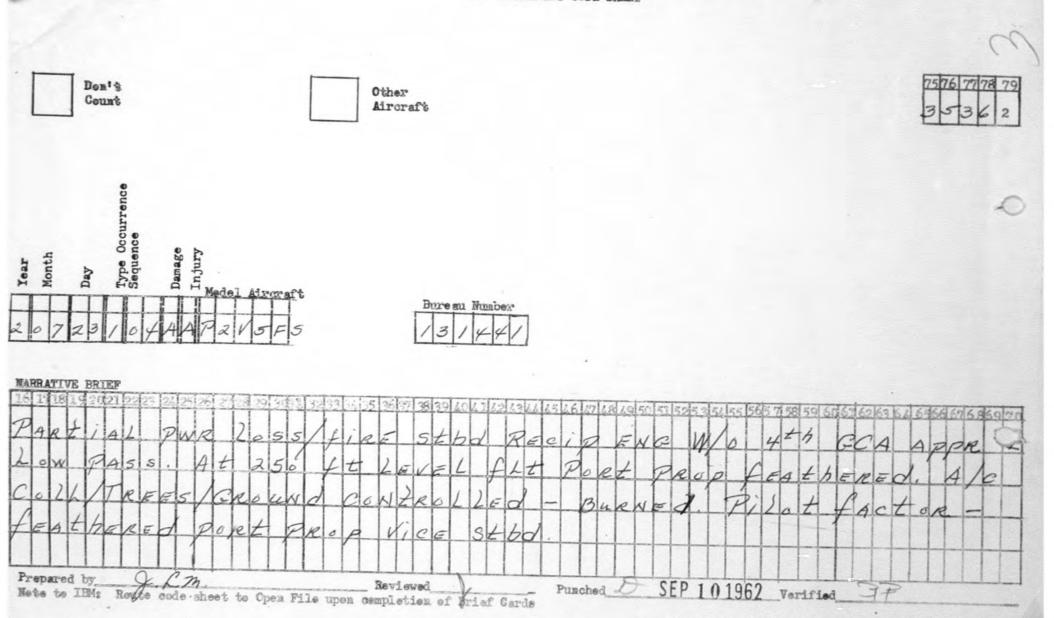
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Bureau Number / 3 / 4	4	4	16-2	1	Weather									16-21
Reporting Custodian 4	40	2:	22-24	1	Kind of	Flight						14	7/	22-24
Type of Duty	20	2:	25-26	5	Relative	Wind - D	irection						X	25
Major Command	0	2	27	1	Relative	Wind - V	elocity						1	26
Aircraft Damage	P	1	28	3	Relative	Wind (Ol	d Code	- Not in	Use)					27
Aircraft Injury	A	1	29		Clearan	ce							2	28
Maneuver prior to Accident	F	3	30		Time of	Doy							2	29
First Accident type	B2	2 3	1-32		Number	of other A	ircraft						1	30
First Accident phase	3	3	3-35		Altitude	of Occurr	ence					00	13	33-35
Second Accident type		3	6-37			Contrib	outing C	ause Fa	ctors	040	2384	13	V	36-37
Second Accident phase		3	8-40			Pilot F				-	11.0		100	38-39
Type of Operation	52	2 4	1-42		R S			el Factor	,			P	2	41-42
Contributing Cause Factors	7	4	3-47		TO		laterial		-	_		17	5	
Pilot Factor, First	VI	- 4	8-49		POSSIBLE	Design		, acror		_			1	43
Pilot Factor, Second	7 0	5	0-51	1	L U.	Facilit							-	44
Pilot Factor, Third	11-	-	2-53	-11		Weathe				_	_			45
First other Personnel Factor	1	-	4-55	+	Non-Nav	y Injury ("			_					46
Second other Personnel Factor	1	-	6-57	-1-		of "A" or	_	mun					1	47
Primary Major Material Factor	D		58					w. Iul	ury	_		4	8	48-49
Secondard Major Material Factor	T	+	59			of "B" Inj						-		50-51
Design	+	+	60	\neg		of "C" In	-							52-53
Facilities	+	+				of "D" Inj					-			54-55
Special Data & Cond. 3 GBMD	+	1	61	1		of "E" Inj	11.	, ,	~	-10				56-57
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FILM/PLAT COVERAGE

Reporting Custodian VP-/C	Serial No. /-62
Type of Report AAR	
Date of Occurrence 7-23-62 MAGNETIC TAPE Type of Film Coverage CONVERSATION TECHNOLOGY	Acft Model 120-5FS
Type of Film Coverage CONVERSATI	No. of Reels 2
NASC Reel ID No. //	

- NOTES: 1. This film coverage may be obtained from the NASC Tech. Library for viewing.
 - When microfilming this report, film this page immediately after the code sheet.

A&R DEPARTMENT CODE SHEET



U. S. NAVAL AVIATION SAFETY CENTER U. S. NAVAL AIR STATION NORFOLK 11, VIRGINIA

NASC:12:ees Ser: 2657 13 December 1962

SPECIAL HANDLING REQUIRED IAW OPNAVINST P3750.6 SERIES

From: Commander, U. S. Naval Aviation Safety Center To: Commanding Officer, Patrol Squadron ONE SIX

Subj: VP-16 AAR ser 1-62 concerning SP-2E (P2V-5FS), BuNo 131441, accident occurring 23 July 1962, pilot McHUGH

- 1. The subject report and all endorsements thereon have been reviewed. The Naval Aviation Safety Center concurs with the comments and recommendations of the Aircraft Accident Board as modified by subsequent endorsers.
- 2. The cause of this accident has been recorded by the Center indicating the pilot as the primary factor and material failure/malfunction as a contributing factor.

(b) (6) Chief of Staff

Copy tos
BUWEPS (F-13) (2)
COMFAIRWINGSIANT
COMFAIRWING 11
CO, NAS GLYNCO
BUWEPSREP BURBANK
BUWEPSREP WOODRIDGE
CO, VP-5, 7, 8, 10, 11, 18, 21, 23, 24, 26, 30, 44, 56
COMNAVAIRIANT
COMFAIRWING 3



19 SEP 1962

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70, OPNAVINST 3750.6D

FOURTH ENDORSEMENT on VP-16 AAR ser 1-62, P2V-5FS, 131441, accident occurring 23 July 1962, pilot McHUGH

From: Commander Naval Air Force, U.S. Atlantic Fleet To: Commander, U.S. Naval Aviation Safety Center

Subj: Aircraft Accident Report

- 1. Forwarded, concurring in the comments and recommendations of the Aircraft Accident Board as modified by subsequent endorsers.
- 2. The comments of the third endorser regarding the use of jet engines is fully concurred in. Commander Naval Air Force, U.S. Atlantic Fleet will submit a recommended change to the P2V-5FS/7 NATOPS Manual con-

By direction

Copy to: BUWEPS (C-131) COMFAIRWINGSLANT COMFAIRWING ELEVEN CO, NAS GLYNCO BUWEPSREP BURBANK BUWEPSREP WOODRIDGE co, VP-5, 7, 8, 10, 11, 16, 18, 21, 23, 24, 26, 30, 44, 56

ORIGINAL

CFAWL/3750 Ser: 312/1164 12 SEP 1962

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARA 70, OPNAVINST 3750.6D

THIRD ENDORSEMENT on VP-16 AAR serial 1-62 concerning P2V-5FS, BUNO 131441, accident occurring 23 July 1962, Pilot McHUCH

From: Commander Fleet Air Wings, U. S. Atlantic Fleet To: Commander, U. S. Naval Aviation Safety Center Via: Commander Naval Air Force, U. S. Atlantic Fleet

Subj: Patrol Squadron SIXTEEN AAR 1-62

- 1. Forwarded, concurring with the comments and recommendations of the board and subsequent endorsements, except as indicated in paragraph 3 below.
- 2. COMFAIRWINGSLANT considers the practice of placing the jet engines in idle particularly important on all actual or simulated instrument approaches, all approaches and landings conducted at gross weights in excess of single engine limits and when a reciprocating engine malfunction is known or suspected to exist. Use of the jets on normal landings should be dependent upon runway foreign object damage hazard.
- 3. Paragraph 1.b.(1) of the second endorsement is not concurred in. While separation of feathering buttons has merit, it is not considered that this is the final solution to eliminating inadvertent feathering in multi-engine aircraft. Past experience has shown this error usually results from too hasty action on the part of the pilot or from lack of cockpit discipline. The action required to eliminate this problem, as with any flight problem stemming from personnel error, is that of recognizing and accepting the need for constant individual and crew familiarization with emergency procedures and the absolute requirement for cockpit discipline in multi-engine aircraft. The attainment of these objectives is the responsibility of each commanding officer, pilot and individual crew member, and only with their attainment can correct positive reaction to emergency situations in aircraft be assured.

Fer. Mal

GEO., P., KOCH

Copy to: CO, VP-16 BUWEPS COMNAVAVNSAFECEN (2) CO NAS GLYNCO GEORGIA RIC, WOODRIDGE, N. J. BUWEPS REP BURBANK

FF12/1-11/302:v1 3750 Ser 555 AUG 3 1 1962

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PARAGRAPH 70 OPNAV INST 3750.6D

SECOND ENDORSEMENT on PATRON SIXTEEN AAR ser 1-62 concerning P2V-5FS BUNO 131441 accident occurring 23 July 1962, Pilot McHUGH

From: Commander Fleet Air Wing ELEVEN

To: Commander Naval Aviation Safety Center

Via: (1) Commander Fleet Air Wings, U. S. Atlantic Fleet (2) Commander Naval Air Force, U. S. Atlantic Fleet

Subj: Patrol Squadron SIXTEEN AAR 1-62; forwarding of

Ref: (a) COMNAVAIRLANT msg 291405Z AUG

(b) COMFAIRWINGSLANT msg 301636Z AUG

- 1. Forwarded, concurring with the comments and recommendations of the basic report and 1st endorsement subject to the following comments:
- a. Part X Recommendation. The basic concept of the recommendation for revising the P2V NATOPS Manual to require that jet engines be placed in idle or standby for instrument low approaches is concurred in. Reference (a) as interpreted by reference (b) provides for jet engines to be operating at idle for all landing approaches including low passes where a waveoff is anticipated; however, this practice should be extended to include all low altitude situations where the loss of a reciprocating engine could develope into a critical situation. It should be noted that the thrust developed by idling jet engines, while small in amount, will necessitate the use of slightly different power settings throughout an instrument approach. By requiring the jet engines to be in idle during practice instrument approaches, the procedure will conform to the requirements for actual instrument approaches as set forth in the NATOPS Manual. It is therefore recommended that the jet engines be operated in idle for all instrument approaches, and that the jet engine be in idle or standby, at the discretion of the pilot, during all other low altitude operations.
 - b. Enclosure 19 of enclosure 22. Recommendation of Medical Officer.
- (1) Recommendation 2. Concur with the recommendation to physically separate the feathering buttons; however, a separation of more than one to two inches should be made. It is recommended that the feathering buttons be relocated, one on either side of the pilot's overhead switch panel.
- c. It is noted that the remarks section of the AAR does not include information required by COMNAVAIRLANT NOTE 3750 of 31 JAN 1962. It has been determined that:

FF12/1-11/302:v1 3750

- (1) No NATOPS requirement or procedure was a factor to the accident.
- (2) The NATOPS Manual was being complied with.
- (3) The accident does indicate the need for a change to the P2V-5FS/7 NATOPS Manual indicated in paragraph 1.a. above.

G.J. Frauenheim

Copy to: CO VP-16 BUMEPS COMMAVAVHSAFECEN CO MAS GLYNCO BUMEPS REP, BURBANK RIG, WOODRIDGE,NJ.

FF12/VP-16/20:1dw Ser 399 17 AUG 1962

FIRST ENDORSEMENT on PATRON SIXTEEN AAR 1-62, P2V-5FS Buno 131141, 23 July 1962, of 15 Aug 1962

Commanding Officer, Patrol Squadron SIXTEEN (VP-16)

c/o Fleet Post Office, New York, New York

Commander, Naval Aviation Safety Center To:

(1) Commander, Fleet Air Wing ELEVEN (2) Commander Fleet Air Wings, Atlantic Fleet Via:

(3) Commander Naval Air Force, U.S. Atlantic Fleet

Subj: Patrol Squadron SIXTEEN AAR 1-62; forwarding of

- 1. Forwarded, concurring with the comments and recommendation of the board.
- 2. This command will initiate correspondence recommending a change to the P2V NATOPS Manual which will require jets to be in standby or idle for all simulated instrument approaches which do not involve a landing.
- 3. Neither pilot had been involved in previous aircraft accidents according to the records of this command. LT McHUGH, the pilot in command, was an experienced Patrol Plane Commander, qualified as an instructor and test pilot in P2V-5FS model aircraft and well experienced in aircraft emergency procedures. IT BROUGHTON was an experienced naval aviator who was making normal progress in transitioning from rotary wing to fixed wing type aircraft after completing training in Patrol Squadron THIRTY. He had not experienced any known difficulty since reporting on board in December Chrodges
 c. E. RODGERS 1961.

Copy to: BUWEPS COMNAVATRIANT COMFATRWINGSLANT COMNAVAVNSAFECEN (2) CO NAS GLYNCO BUWEPS REP, BURBANK RIC, WOODRIDGE, N.J. RIGINAL

AIRCRAFT ACCIDENT REPORT

SPECIAL HANDLING REQUIRED in accordance with Para. 65, OPNAV INSTRUCTION 3750.6C

ORIGINAL

OPNAV REPORT 3750-1

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^{*} Relates to take off/landing direct

COMMUNICATIONS OFFICER

USN

LT,

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UNIT BELLET

PART V THE ACCIDENT

On 23 July 1962 P2V-5F BUNO 131441 received take off instructions from the control tower, NAS Jacksonville, Florida, and took off at 0835 EST with a crew of six on board. The aircraft had a fuel load of 2300 gallons, with a gross weight of 68,676 pounds. The flight was scheduled as a 6.0 hour local flight on Patrol Squadron SIXTEEN (VP-16) flight schedule for 23 July 1962. The mission as scheduled was to be Instrument 7 (GCA) from the COMFAIRWINGSLANT flight training syllabus. A concurrent mission was to have been an operational and functional check of equipment and systems prior to transfer for induction into the PAR program on 8 August 1962. This was to be done throughout the entire flight and no specific time assigned for this purpose. A pre-transfer flight test sheet was issued to the pilots by the Squadron Quality Control Officer prior to taxi.

After approximately one hour and fifteen minutes of flight the aircraft commenced practice GCA approaches to low passes, in VFR conditions, to runway 25 at NAS Glynco, Brunswick, Georgia. The first three practice approaches were normal in all respects. The fourth approach was a no gyro approach to GCA minimums (100 feet and one quarter mile), and low pass. After the aircraft executed a wave off from this approach witnesses in the vicinity of the airfield observed smoke trailing from the starboard reciproceeding engine. The aircraft proceeded down runway 25 at approximately 250 feet of altitude in level flight. Shortly after the aircraft passed the upwind end of the runway a control tower operator, using binoculars, observed the port propeller to go into full feather and stop. The port wing dipped momentarily. The aircraft then proceeded straight ahead, wings level, in a shallow glide and disappeared into the trees. Immedi-

ately thereafter a large ball of fire was observed.

The crash occurred at 1044 EST after two hours and nine minutes of flight at approximately two miles beyond the upwind end of runway 25. The estimated aircraft weight at this time was 64,746 pounds. The crash circuit at NAS GLYNCO was energized at 1044 EST by control tower. personnel. A rescue helicopter arrived over the crash scene approximately ten minutes later. An MB-1, fire fighting truck, arrived about twenty minutes after the crash, having proceeded through a heavy growth of pine trees, brush, and palmeto, seemingly impenetrable by ground vehicle. At the time that rescue personnel and equipment arrived, the aircraft was engulfed in heavy flames, with no apparent indication of survivors. Rapidly spreading fire through the underbrush hampered attempted rescue operations; however, the MB-1 was able to discharge its full supply of foam over portions of the burning wreckage. The aircraft wreckage was positively identified as BUNO 131441 by the numbers on the vertical stabi-

PART VI DAMAGE TO AIRCRAFT

The arrcraft received ALFA damage as it progressed through the trees and on impact. The ensuing fire consumed the majority of the airframe in the immediate vicinity of the final impact point. Various parts which were torn loose from the aircraft during its descent through the trees were not subjected to fire. Wreckage distribution is illustrated by enclosure 1. Pamage encountered by sub-assemblies is as indicated below:

FUSELAGE

Everything was consumed by fire back to where the empennage was torn off (jagged between stations 735 and 764.4) with the exception of wiring, avionics gear, control cables and components constructed of steel. The appearance of the debris indicated that the fuselage remained generally intact as evidenced by the location of: nose gear assembly, cockpit upper pedestal control handles, fuel panel stems, flight deck avionics gear, radio compartment chair, UHF transceiver box, galley stove, oxygen bottles, retro launcher and parts of the sonobuoy chutes. The main body came to rest 450 relative to the flight path.

EMPENNAGE

The main body of the empennage remained intact and was not consumed by fire. The top seven feet (station 122.25) of the vertical stabilizer and rudder was sheared. The outer tip of the starboard horizontal stabilizer, varicam, and all of the elevator was sheared off by the trees, 360 feet short of the final impact point. All but approximately 3 feet of the port varicam, elevator, and horizontal stabilizer were located 294 feet short of final impact. The bottom portion of the tail section was ripped open, 3 feet wide, from an undetermined point forward of station 735 aft to station 794.

PORT WING

The outer $9\frac{1}{2}$ feet (station 473) was sheared off 252 feet short of the final impact. The top skin was peeled upward. The remainder of the wing (station 0 to 473) was consumed by fire with the exception of flap drive screws, some gear boxes, fuel valves (except the engine selector valve), and various steel components. The debris indicated this part of the wing generally remained intact.

STARBOARD WING

The outer $9\frac{1}{2}$ feet (station 473) was sheared off in exactly the same location and manner as the port, and was found 114 feet short of final impact. The remainder of the wing was damaged in the same manner as the port except all fuel valves were located.

JET ENGINES

The port jet engine was torn off short of the final impact and was located only 18 feet from the rear section of the fuselage. The engine was fairly well intact with doors missing, nose section bent, nacelle bent, turbine wheel broken, and the tail cone located 264 feet short of

The starboard jet was torn off 90 feet short of the final impact and experienced severe damage similar to the port jet. Neither engine experienced fire damage to any extent.

RECIPROCATING ENGINES

The left engine was pointed in the direction of flight, 12 feet from the cockpit area. The accessory section and nose section were consumed by fire except for gear trains and other steel parts. The power section was generally intact with the majority of the cylinder heads, destroyed by fire. Valves for these cylinders were in the immediate vicinity of the engine.

The starboard engine was laying on its right side pointing 270° relative to the fuselage, and 8 feet from the cockpit area. This engine experienced damage similar to the port engine except that the

cylinder heads were generally in better condition.

PROPELLERS

The port propeller was intact and located immediately in front of the port engine, laying dome down with the propeller shaft completely severed. All blades were bent and severely damaged. The propeller spinner was torn off and consumed by fire. The governor for this propeller was intact.

The starboard propeller was laying dome down to the left of the starboard engine, but immediately behind the engine relative to the flight path. One blade was torn loose from the hub. The remaining three blades and the spinner remained attached but were severly bent

and damaged.

LANDING GEAR

The port main gear remained in the up position in the port nacelle with the tire consumed by fire.

The starboard gear assembly and its mounting structure were torn loose from the airframe with the gear apparently in the down position. The nose gear assembly was not intact.

PART VII THE INVESTIGATION

Introduction "

The investigation began shortly after the accident occurred. First investigators on the scene were LCDR (b) MAS Glynco Aviation Safety Officer and LCDR (b) (6) Fleet Air Wing ELEVEN Aviation Safety Officer, both of whom arrived in less than one hour. LT (b) (6) Patrol Squadron SIXTEEN Aviation Safety Officer and a member of the Aircraft Accident Board, arrived at the crash scene approximately one hour after the crash. Doctor (b) (6) LT, USN(MC), Fleet Air Wing ELEVEN flight surgeon, and a member of the Patrol Squadron SIXTEEN standing Aircraft Accident Board, arrived within one hour and thirty minutes after the crash.

The initial investigation of aircraft wreckage and surrounding environs was seriously hampered due to persisting fire. Doctor [5] (6) confirmed the fact that none of the six crewmembers had survived the crash and made an initial diagnosis of cause of death as injuries, multiple and extreme, in all cases. Although the remains of all crewmembers had been burned beyond recognition, positive dental identification later showed the crewmembers to be:

LT Philip R. McHUGH, USN LT James A. BROUGHTON, USN Ronald W. ANDERSON, ADR3 James V. CAWTHON, ATCA Kenneth J. MOSELER, AE2 Harry C. WILLIS, ADR3

On the scene investigation during the remaining daylight hours of 23 July was limited to witness interrogation, general examination of wreckage, and determination of the positions of the remains of the individual crewmembers within the wreckage. When it was learned that the aircraft was on a practice GCA prior to the crash and that the GCA run had been recorded, LT (b) (6) proceeded to obtain and listen to the tape recording. The remaining members of the Aircraft Accident Board arrived at NAS Glynco at 2145 EST on 23 July. All members of the accident board remained at NAS Glynco from 23 July to 27 July, gathering evidence and supervising removal of the entire wreckage to a hangar area where it could be examined in detail. During this period technical assistance was rendered by Mr. (b) (6) Lockheed Technical representative, and a group of highly qualified squadron maintenance petty officers. Evidence discovered during the course of the investigation can be divided into the following catagories and will be discussed as such: The tape recording, a transcript of which is enclosure 2 (A magnetic tape copy of which is enclosure 3, forwarded under separate cover with the original of this report), witnesses statements (enclosure 5), examination of wreckage, training and background of the pilots and plane captain involved, and maintenance records of the aircraft.

THE TAPE

The tape recording that was made, as a matter of standard practice, by the controlling GCA unit, is a unique article of evidence in that an apparently stuck microphone button in the cockpit of the aircraft caused sounds in the cockpit to be transmitted over UHF and therefore recorded.

The GCA approach was the fourth for the aircraft and all aproaches seemed to be normal in all respects. The GCA unit used a student controller. The aircraft flight evolutions during the fourth approach were apparently smooth and well coordinated. Members of the Aircraft Accident Board identified the voice of the pilot acknowledging for GCA transmissions during the approach as that of LT McHUGH. "Spangle 12" (the tactical voice call of the aircraft) came down the glide path holding just slightly above the glide path two and one half miles from the GCA touchdown point which is loacted 500 feet from the end of the runway. By one mile "Spangle 12" was on the glide path and receiving small heading corrections utilizing no gyro approach procedures. At one quarter mile the GCA controller advised the pilot that he was on glide path at precision minimums and should take over visually. At this point the runway centerline was reported straight ahead. The aircraft was observed, on radar, to level off as it passed over the end of the runway. "Spangle 12" was advised to climb straight ahead to 500 feet upon completion of the low pass. Twenty four seconds after passing over GCA touchdown point the voice of LT BROUGHTON as identified by members of the board started to roger for the last transmission of the GCA Controller. From this point on the mike button remained depressed and cockpit sounds were transmitted. LT BROWHTONS transmission was interrupted. Four seconds later the sound of ANDERSON's voice, remote from the transmitting microphone and identified by enlisted personnel familiar with his voice, shouted "Feather it! Feather". Two seconds after the third "Feather" there was a noticeable decrease in the engine noise being transmitted. Six seconds later there was a sound similar to a muffled explosion transmitted, seven seconds later a crunching sound, one second later LT BROUGHTON's voice transmitted "we're going it, this is Spangle 12", and 21 seconds later what appears to be the final impact sound, was transmitted from the aircraft.

WITNESS

Since the aircraft passed over the runway at NAS Glynco immediately prior to crashing and crashed in the proximity of the airfield, many experienced, competent, and qualified witnesses were available. The vantage points of these witnesses is illustrated in enclosure 4. Initial witness interrogation was made on 23 July by LCDR (b) (6) and ICDR (b) (6) NAS Glynco Operations Duty Officer. Further questioning of witnesses was done by members of the board on 24 and 25 July. All witnesses statements are included as enclosure 5 in the order mentioned hereafter. Evidence obtained from witness observation is outlined below: STATEMENT OF (b) (6) SA, (WHEELS WATCH)

(b) (6) position on the airfield enabled him to observe and hear the aircraft as power was applied for level off approaching the runway. His description is the first evidence that a component of the aircraft's power plant system was malfunctioning, and places the time of initial malfunctioning as "a few seconds" after the application of power to stop rate of descent. The malfunction is defined as a malfunction of the starboard reciprocating engine when Birgen says, "black smoke poured from the top of the engine and the right prop was cutting off and on".

is a creditable witness concerning his ability to observe and report, however, his ability to estimate distances and altitudes is limited due to a lack of experience. STATEMENT OF (b) (6)

ACI, (CONTROL TOWER) was interrogated by members of the board in the control tower at NAS Glynco on 24 July. He first observed the aircraft a little past midfield (about abeam the tower) and reports that " his starboard jet appeared to me to be smoking". Using binoculars, the witness observed the port reciprocating engine "being feathered and come to a complete stop" when the aircraft was "about over the numbers, west end of the runway, at about 200 feet of altitude". The most significant evidence obtainable from this witness! observations is the port propeller feathering. Members of the board using the same binoculars that he used, standing on the same spot he stood, observed multi engine aircraft flying over the approximate position that (b) reports the port engine of "Spangle 12" was feathered. The propellers from this vantage point were clearly visible. At the time (b) sew the aircraft fly abeam the tower he was not in a position to determine whether smoke was coming from the starboard reciprocating or starboard jet engine. (b) is a completely creditable witness.

Chief (b) was questioned at the GCA trailer on 24 July by members of the board. On the day of the accident he was located at the most favorable position to observe the starboard side of the aircraft. His statement establishes as fact the malfunction of the starboard reciprocating engine. When first questioned by members of the board on 24 July Chief (b) could not recall hearing the sound of jet engines, or the absence of jet noise, at the time "Spangle 12" passed over the GCA trailer. However, after listening to a P2V with jets operating pass overhead on 24 July the witness concluded that on 23 July as "Spangle 12" flew by the GCA trailer "jet engines were not running". Chief (b) (6) is a highly reliable and creditable witness. WITNESS EVALUATION OF JET ENGINE OPERATION

A group of creditable witnesses located at the jet line observed the aircraft proceed down the runway. Statements from various people, all within close proximity, differ concerning jet engine operation from abeam the jet line until crashing. Up to this point we have the word of Chief (b) and (b) (6) ACl, at the GCA trailer, and (b) (6) AN, at the crash truck that the jet engines were not running. Further observations vary from no jet noise (statement of (b) (6) to noise of jet or jets at idle RPM but no faster (statement of (b) (6) (b) (6) AMH3), to maximum RPM jet noise (statement of (b) (6) ADDITIONAL WITNESS OBSERVATIONS

According to witnesses at all of the above mentioned ventage points the landing gear was fully retracted as the aircraft proceeded across the airfield. Descriptions of the flight path and attitude of the aircraft indicate that except for loss of altitude, the aircraft was fully under the control of the pilot. WRECKAGE

The investigation of wreckage for evidence leading to the cause of the accident was divided into three phases: On the scene examination, detailed examination in a hangar at NAS Glynco, and disassembly inspection of power plant components by overhaul and repair facilities.

Distribution of wreckage at the crash scene is illustrated in enclosure 1. The following observations were made at the crash scene by members of the board on 23 and 24 July:

1. Port propeller blades were apparently in the feathered position and bent so as to indicate no rotation at the time of impact

2. Starboard propeller blades were apparently in a flat blade angle position and bent so as to indicate low or no RPM at impact

- 3. All flap drive screw jacks except one were in such a position so as to indicate flaps up (or nearly so) at time of impact. The remaining screw jack was bent and set at a position other than full
- 4. The port landing gear was in the up position in the port engine nacelle.
- 5. The starboard landing gear assembly was in the down and locked position.
- 6. The throttle quadrant and upper pedestal although recoverable did not yield useable evidence because of the effect of high G forces along the longitudinal axis upon components confined to movement along that axis. However, some credence may be given to detent type handles such as mixture controls, which were both rich and jet throttles, which were forward of the standby detent.

7. Two jet gages found were determined to be at zero percent RPM and approximately 25 percent RPM readings. It was impossible to correlate each gage with a port or starboard engine at this time.

8. Cursory examination of the jet engines showed extremely limited bending of blades and damage to the turbine and compressor section.

On 24 and 25 July squadron maintenance personnel assisted by working parties from NAS Glynco and supervised by members of the board, transported all recoverable wreckage to a hangar at NAS Glynco. On 26 July highly qualified and experienced squadron senior maintenance petty officers were called upon to assist the board in making the following

1. The fuel system components found were used to reconstruct the mode of operation of the fuel system at the time of crash as illustrated in enclosure positions of valves illustrated in enclosures 8 and 9, determined from examination of the valves except in the case of the port side engine selector valve. In this case it was determine that the valve was shutting off the fuel to the port reciprocating engine from the position of the chain end relative to the gear on the fuel panel stem. Starboard oil and hydraulic firewall shut off valves were in the shut off position as illustrated by enclosure10.

2. Port propeller dome setting was full feather (as illustrated

by enclosure 11).

3. Starboard propeller dome setting was full low pitch (as illustrated by enclosure 12).

4. Both mixture plates were near cut off. 5. Varicam setting was apparently zero.

6. The starboard jet throttle actuator was set at 100 percent RPM (as illustrated by enclosure 13).

7. The port jet throttle actuator was set at 100 percent RPM (enclosure 14).

8. The starboard jet fuel valve was in the open position. (enclosure 15). On 28 July the four engines were shipped to appropriate overhaul and repair facilities for disassembly and inspection. The preliminary DIR is enclosure 18.

MAINTENACE RECORDS OF AIRCRAFT

The Logs, Records, Discrepancy reports and work orders were re-

viewed by the board.

All aircraft services changes, other than armament and electronics which are not pertinent to this report, had been incorporated with the exception of:

851 - Wings; Replacement and/or repair of ribs in flaps for the

outer wing panel.

859 - Furnishings - Installation of hood over galley stove.

861 - Power Plant - Installation of cockpit lights and associated wiring for chip detector plugs.

*8744 - Propulsion System; Installation of engine manual spark advance and Rich/Auto lean carburetor provision.

872 - Furnishings - Flight Deck ditching station-Relocation of.

875 - Photographic - Installation of provisions for ASW Camera pod.

877 - Installation of dual 30KVA constant frequency power.

878 - Power Plant - Replacement of self-sealing fuel tanks, oil tanks, and hose assemblies with bladder type fuel and oil tanks and light weight hose assemblies.

880 - Flight Control; Friction Disc Control Stand Lever-Replace-

ment of.

888 - Jet engine control circuit breakers guard.

894 - Taxi light- Installation of.

895 - Modification of fuel pump shaft seal drain line bulkhead fitting.

Engine bulletins for jet and reciprocating engines which had not

been incorporated are included as enclosure16.

All discrepancies that were written on the aircraft during the past six months were reviewed. Two oil pressure discrepancies were written on the starboard reciprocating engine for low oil pressure (60-65psi) on 6th and 7th of June which were corrected with no further indication of malfunction. The aircraft flew with two outstanding electrical discrepancies listed below:

1. "Master lever will not run propellers to full increase RPM - Toggles OK". After reviewing this discrepancy it was revealed that the Master Lever would not close the circuit to the low pitch lights. However, the propellers were in full low pitch, evidenced by the fact that when the toggles switches were energized the lights immediately came on.

2. "50 RFM split with the propellers in SYNC".

This was considered as an instrument error and was not a safety of flight discrepancy. The Quality Control Officer discussed both of the above discrepancies with the pilot and plane captain prior to taxi. The pilot signed the form A of the yellow sheet with an entry that he had reviewed all discrepancies in the form B book, which included B sheets subsequent to 27 February 1962.

The last maintenance inspection was a major calendar inspection completed on 13 July 1962. A review of the inspection sheet indicates

that required work was performed and properly supervised.

*Note: All of ASC 874 had been incorporated with the exception of Revision A.

The daily preflight sheet indicates that aircraft components, with the exception of electronics gear, were properly preflighted by the plane captain. The pilot noted on the preflight sheet that he accepted the aircraft. without an electronic preflight but would check out this equipment in flight.

TRAINING AND BACKGROUND OF PERSONNEL INVOLVED

1. LT PHILIP R. McHUGH, (b) (6) (1310, (PILOT IN COMMAND) This 29 year old LT entered the Navy on 9/23/55. He was designated a Naval Aviator on 7/30/57. He reported to Patrol Squadron SIXTEEN on 7 Nov 1959 from Fleet Airborne Electronics Training Unit, Atlantic, Detachment TWO, NAS, Jacksonville, Florida. He was designated PP3P on 3/29/60, PP2P on 8/1/60 and FFC on 6/13/61. LT McHUGH had a standard instrument rating which was due to expire on 7/29/62. He had completed his annual physical on 7/20/62. LT McHUGH previous flight experience included S2F (59.5 hours), SNB (198.6 hours) and TV (24.4 hours). A review of his training record and past perfomance indicated LT McHUGH was a highly qualified Patrol Plane Commander. He was a squadron designated test pilot and instructor pilot.

2. LT JAMES A. BROUGHTON, (b) (6) (1310, (PILOT UNDER TRAINING) He was desig-This 29 year old LT entered the Navy on 2/7/54. nated a Naval Aviator on 12 July 1955 and a received a helicopter designation on 16 April 1958. LT BROUGHTON reported to Patrl Squadron SIXTEEN on 12 December 1961 from Patrol Squadron THIRTY where he had received replacement pilot training in PZV-5F aircraft. His previous assignment had been with Helicopter Utility Squadron ROUR (HU-4). He was designated PP3P in P2V aircraft on 11 June 1962. He had a standard instrument rating which was due to expire on 11 December 1962. His last annual physical was completed on 21 Dec 1961. LT BROUGHTON's previous flight experience included 795 hours of helicopter time, including operations in Antartica. Due to the fact that LT BROUGHTON had been flying helicopters from February 1958 until he reported to Patrol Squadron THIRTY in September 1961 and his recent fixed wing experience extremely limited, his training was being conducted under the COMFAIR-WINGSIANT first tour pilot syllabus. LT BROUGHTON had been progressing througho the COMFAIRWINGSIANT P2V Pilot Flight Training Syllabus satisfactorily with no indication of difficulty transitioning to fixed wing

(PLANE CAPTAIN) aircraft. This Aviation Machinist Mate Third Class would have been 21 years ANDERSON, RONALD W., ADR3, (b) (6) He entered the Navy on 25 February 1960 and reported to Patrol Squadron SIXTEEN on 11 January 1961. He was advanced to ADR3 on 16 November 1961. On 9 June 1961 he completed a NAMTD R3350 maintenace course given by the Naval Air Mobile Training Group, NAS Jacksonville, Florida. Anderson was qualified as a plane captain in P2V-5F aircraft on 7 May 1962 in accordance with COMNAVAIR-LANT Instruction 1616.2A. He had not requalified in accordance with COMNAVAIRLANT Instruction 1616.2B of 27 March 1962. He had his last flight physical on 16 July 1962. Anderson commenced flying in Patrol Squadron SIXTEEN on 23 May 1961 and since that time accumulated 520.9 hours in P2V aircraft. His training record, as maintained by the power plants division, indicates that he satisfactorily demonstrated the capability to perform all inflight plane captain duties.

PART VIII - THE ANALYSIS

GENERAL

The aircraft was on an authorized flight with a qualified crew and was being conducted as scheduled. The aircraft had been properly preflighted. The pilot accepted the aircraft with known discrepancies which the board feels did not affect safety of flight. The weather as reported in enclosure 17, was not a contributing factor. When the aircraft taxied at NAS Jacksonville, LT McHUGH, the PPC, was observed by line personnel to be in the right seat. All factors having a bearing on the accident will be discussed under the headings of material, personnel and supervisory.

MATERIAL

The only unincorporated Aircraft Service Changes or Engine Bulletins which could have had any bearing on the accident were: (1) ASC 861, installation of Chip Detector warning lights in the cockpit, (2) ASC installation of dual 30 KVA constant frequency power. The warning 877, installation of dual 30 KVA constant frequency power. The warning lights, if installed, possibly could have given the pilot some forewarning of engine malfunction. The dual 30 KVA electrical system would have ing of engine malfunction. The dual 30 KVA electrical system would have resulted in a lighter electrical load on the main DC bus at the time of the emergency, thus providing the necessary power to crank start a jet engine without taking the time to reduce the electrical load by securing any of the inverters. The fact that the final UHF transmission of the aircraft was as strong as those received prior to the emergency precludes complete loss of electrical power to the main D.C. bus being a contributing factor.

The outstanding discrepancy concerning the propeller low pitch lights could not have been a contributing factor. The pilot was able to set both propellers at full low pitch. This is evidenced by the fact that the port prop governor was found set at full increase RPM and that the tarboard propeller dome was mechanically set at the low pitch stops.

The reciprocating engines and limited accessories which were sent to O&R for disassembly and inspection were in such poor condition that the report can be accepted as completely valid only with regards to the remaining components of the power section of the engines.

The preliminary DIR reveals no evidence of malfunction of the star-board reciprocating entine. However, reliable witnesses, being in position to observe the starboard engine, produced strong evidence of a malfunction associated with a rough running engine, smoke and fire. This evidence is not inconsistent with the preliminary DIR in that the difficulty, if confined to the ignition or induction systems, would not have been revealed in the disassembly and inspection.

Based upon witnesses observations and the preliminary DIR indicating no significant discrepancies, it is concluded that the port engine was capable of being operated normally prior to feathering. The burned valves from the port engine as reported in the preliminary DIR subsequently have been determined by laboratry analysis to have been burned by fire associated with the crash.

It is concluded from witnesses' statements and the path of the aircraft through the trees, which average a height of 80 feet, that the aircraft was under control of the pilot and that malfunction of control surfaces is not a contributing factor.

PERSONNEL

At a low altitude, the likelihood of recovering from a loss of power on one reciprocating engine, with the jet doors closed, would depend primarily on the single engine capability of the aircraft. The aircraft weight at the time of the crash, as estimated by members of the board, was 64,746 pounds. At this weight, using military rated power on the good reciprocating engine, the aircraft had single engine operating capability. At normal airspeeds for the low pass phase of the approach and at an altitude of approximately 250 feet, a successful recovery from the loss of power of one of the reciprocating engines would have been possible. The NATOPS Manual recommends maintaining at least 141 knots CAS at 65,000 pounds for single engine climb. It is probable that the aircraft was at or very near this airspeed at the time of the emergency. Although the aircraft had the capability of single engine flight, rapid analysis and positive action would be required on the part of the pilot.

All available evidence positively establishes the fact that the port propeller was feathered. In order to determine where the propeller was feathered, an attempt was made to graphically relate sounds on the tape recording with witness observation and the aircraft's progress over the ground (enclosure 4). An average ground speed of 130 knots (217 feet per second) was assumed. This assumption is based on the fact that members of the board calculated, from the tape recording, an average ground speed of 127 knots on GCA final approach. This graphic analysis places the position of the aircraft at the time of port propeller feathering. This position precludes the likelihood of feathering the propeller in connection with normal ditching procedures.

With no evidence of port engine malfunction, the reason for feathering this engine is undetermined. The most probable reason is either incorrect analysis of the existing emergency or inadvertent pushing of the wrong feathering button. Either of these mistakes could be the result of haste on the part of the pilot in connection with the rapid action required in handling an engine emergency, involving fire, at a

low altitude. With the port engine feathered and some undetermined loss of power on the starboard engine, the pilot was in dire need of power from the jet engines. If he had been following Standard Operating Procedures the jet doors would have been closed. The emergency must have been recognized and jet doors opened shortly after passing over GCA touchdown point. The NATOPS Manual states that at 140 Kts IAS, 33 seconds would be required to windmill the jets to the necessary 8% to ignite. Approximately 15 additional seconds would be required for ignition and acceleration to 100%. Therefore, immediate. action upon first indication of engine malfunction would have permitted 100% power on both jets shortly after the port engine was feathered. However, the witnesses observations, particularly that of Captain Perkins, places the position of the aircraft at the time of obtaining jet power well beyond the point of feathering. With the aircraft losing airspeed and altitude at this point very little time was available for the jets to develop 100% power. If the aircraft was on the backside of the power curve at this point, recovery at such a low altitude would have been improbable even though the jets were approaching 100%.

The port fuel tank selector valve was found in the closed position, thus denying a source of fuel for the port jet. In order for the port

jet to be operating at a speed somewhere between idle and normal at impact, as indicated by the DIR, this valve must have been closed immediately prior to impact or as a result of impact. The same conclusion is made for the oil and hydraulic firewall shut off valve to the starboard reciprocating engine (enclosure 10) since the preliminary DIR reveals no evidence of oil starvation in this engine and it was in fact developing some power on impact. The unusual fuel system mode of operation found after the crash has therefore been determined to have been a result of either a last minute preparation for the crash or a result of impact. There are no indications of fuel panel mismanagement.

Another possible personnel contributing factor is the use of flaps. Standard Operation Procedure call for 20 degrees of flaps on GCA final, and for low passes that flaps be raised only upon reaching an altitude of 300 feet. Time distances checks of the controllers transmissions reveal: an average ground speed of 127 knots on final approach leg. This speed is consistent with a 20 degree flap setting. The flap drive screw jacks established the fact that flaps were up at the time of impact. When the flaps were raised is undetermined. Although witnesses did not observe any changes of attitude associated with raising the flaps, it is possible that flaps were raised in small increments as the aircraft proceeded down the runway. Another possibility is that flaps were raised after the feathering of the port propeller in a desperate attempt to gain airspeed by reducing drag. Such action could have resulted in a sink rate sufficient, at this low altitude, to cause collision with the trees.

SUPERVISORY

Past Standard Operating Procedures and the NATOPS Manual do not require the use of jets other than on approaches where the weather is below 500 feet ceiling and 1 mile visibility. If the use of jets in either the idle or standby position for practice GCA low passes had been a standard operating procedure, it is quite obvious that less pressure for hasty action would have been exerted upon the pilot in this particular emergency.

PART IX - COMMENTS

The primary cause of the accident was personnel error in that the wrong propeller was feathered. This action could have been physically accomplished by either of the pilots or the plane captain.

In addition to the above, the following contributing factors were

present in the accident.

(1) There was an undetermined malfunction of the starboard reciprocating engine which was accompanied by fire. This is significant in that it occurred at a low altitude whereby rapid action was required on the part of the pilot. Partial loss of power on this engine, in itself, was not significantally critical.

(2) The Standard Operating Procedures do not require the use of jet engines in standby or idle while making practice GCA approaches to low passes. Having jets readily available would have required less action on the part of the pilot during the emergency thereby reducing

the pressure for hasty action.

(3) The possible untimely raising of flaps just prior to collision with the trees could have been critical in itself, due to a resulting loss of altitude.



PART X - RECOMMENDATION

It is recommended that Standard Operating Procedures be revised to require jets being placed in standby or idle when practicing instrument low approaches which do not involve a landing.

X RECOMMENDATIONS 26

STATEMENT OF (b) (6)

I have been in the Navy for about five months.

On 23 July 1962, I stood about my tenth four hour wheels watch at NAS Glynco, Georgia. I was on wheels watch when the plane was making overpasses. On the third overpass that I saw the plane looked like it was landing. On the pass the plane was lower than the other passes. When It was approximately 50 feet from the runway, the engines on the plane started running faster as to make another overpass. A few seconds after the engines were run faster, the engine on the right side, or the engine on the side nearest the wheel watch, made a sound like a backfire and black smoke came streaming out. No parts fell from the plane. Black smoke poured from the top of the engine and the right prop was cutting off and on. He tried to climb but never did until he was clear of the runway. It kept an approximate 20 feet until the end of the runway. The engines were still running wide open but poured more smoke. The plane was off the approach end of runway 7 when it picked up altitude for about 10 seconds, then it went down. As soon as the plane dropped a flame hundreds of feet high went up.

(b) (6)

ENCLOSURE 1507

U. S. NAVAL AIR STATION

JACKSONVILLE 12, FLORIDA

IN REPLY REFER TO:

9 AUG 1962

From: Commanding Officer, NAS, Jacksonville 12, Florida

To: Commanding Officer
Patrol Squadron 16
Naval Air Station
Jacksonville 12, Florida

Subj: Request for oil analysis for metal contamination; report on

Ref: (a) VP-16 Work Request no. 121-62 of 2 Aug 1962 with COMFAIRJAX 1st end. of 2 Aug 1962

- 1. Reference (a) requested an analysis of the oil remaining in 2 fire damaged oil coolers to determine the presence of metal contamination. The 2 oil coolers were received on 2 August 1962.
- 2. The fire damage to one of the oil coolers was so extensive that no analysis could be performed. An X-ray of this oil cooler was not effective in locating any metal particles. Further work was discontinued.
- 3. An X-ray of the 2nd oil cooler, possessing negligible fire damage, revealed an unusually clean oil cooler practically devoid of metal particles. The condition of this oil cooler was such that the few small metal particles could not have interfered with the performance of the oil cooler. Following the flushing of this oil cooler and collection of the material removed, several charred particles of rubber possessing thread marks were present. These had been removed from the valve portion of the cooler. Analysis of the minute metal particles was considered unnecessary since they were so small in size.
- 4. The rubber particles were believed to have originated from a charred portion of a hose connected to the oil cooler since the threads of the rubber corresponded to the threads of the tubing to which a hose had been fastened. Analysis failed to reveal any contributing factor toward engine malfunction.

By direction

CONFAIRJAX

1962 AUG 9 AM 4 52 ATTU: 30/STD PRI INVESTIGATION, J34-WE-34 ENGS BUNO 200655 AND 201614 A. BUWEPSFLTREADREPLANT 261524Z JUL 1. DISASSEMBLY AND INSPECTION OF J34-WE-34 ENGS BUNOS 200655 AND 201614 FROM CRASHED P2V-5FS BUNO 131441 CONDUCTED AS REQUESTED IN REF A AND B

2. NO DISCERPANCIES NOTED IN EITHER ENG OR ACCESSORIES RECEIVED TO INDICATE MALFUNCTION WHICH MIGHT BE CONTRIBUTING FACTOR TO ACCIDENT. 3. FUEL CONTROL SER SECO 52 REPORTEDLY FROM PORT ENG BUNG 200655 FOUND REF 26152LZ: PATRON 16 REQ SHIP R3350-36WA ENGS AND PR PS.,, ETC.,, 251800Z; RELIABLE WITNESSES REPORT STED ENGINE FIRE ... ETC. ..

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PRELIMINARY REPORT.

B. PATRON ONE SIX 251800Z JUL

TO BIWEPSFLTREADREPLANT PWTRON ONE SIX -INFO NAS NORFOLK

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PAGE TWO RUCKEK 16 TO BE IN APPROX 40 DEGREE THROTTLE ANGLE (68 PERCENT RPM) POSITION. FUEL CONTROL SER 5996A REPORTEDLY FROM STBD ENG BUNO 201614 FOUND TO BE IN APPROX 20 DEGREE THROTTLE ANGLE (40 PERCENT RPM). THESE THROTTLE ANGLES NOT NECESSARILY ANGLES PRIOR TO CRASH IMPACT SINCE BOTH CONTROLS SUSTAINED IMPACT DAMAGE. 4. AS EVIDENCED BY LARGE QUANTITY OF FINE LIMBS, TWIGS, LEAVES, ETC. INGESTED, PULVERIZED AND COMPACTED INTO COMPRESSOR OUTLET SCREENS ENGS APPARENTLY OPERATING NORMALLY AT AN UNDETERMINED SPEED SOMEWHERE BETWEEN IDLE AND NORMAL AT TIME OF CONTACT WITH TREES. 5. NO FURTHER REPORT TO BE SUBMITTED UNLESS REQUESTED. BT

NASC/60/ed Ser: 1878 20 August 1962

From: Commander, U. S. Naval Aviation Safety Center

To: Chief of Naval Operations

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Subj: NASC Investigation 35-62 concerning the accident of P2V-5FS BUNO 131441 occurring on 23 July 1962 near NAS Glynco, Georgia

- The subject aircraft with LT P. R. McHUGH as PPC, occupying the right seat, and LT J. A. BROUGHTON a qualified PP3P, occupying the left seat, crashed one mile off the up wind end of Runway 25 following a practice GGA Low Approach. The aircraft was a strike. The crew of six received fatal injuries.
- 2. The investigation revealed the following:
- a. The aircraft and crew were attached to VP-16 stationed at NAS Jacksonville.
- b. The purpose of the flight was local training and 2.1 hours had elapsed of a scheduled 6.0 hour flight. Four practice GCA approaches to a low pass were made at NAS Glynco.
- c. On the fourth GCA approach an airspeed of 125-130 kts was maintained on final. Upon completion of the approach power was applied to execute a low pass. As the power was applied the starboard engine was observed to "cut-out" and emit black smoke. The starboard engine continued to cut-out with fire and smoke emitting from the top portion of the engine, at approximately \$\frac{1}{2}\$ of a mile beyond the end of the runway the port engine propeller was observed to go to the feathered position. Jet engine noise was heard prior to the feathering of the port engine.
 - d. The investigation of the impact area and the wreckage revealed that:
- (1) The initial impact was between the radome and the tops of 80-100° trees. A slight amount of altitude was gained followed by a 10°-15° angle of impact with trees in a nose high altitude. The aircraft continued to settle shearing trees and severing portions of the aircraft. Final impact was made with the ground in a nose down, right wing down attitude followed by severe fire.
 - (2) The starboard propeller was in the full low pitch position.
 - (3) The port propeller was in the full feathered position.
 - (4) The port recip engine selector was in the off position.
 - (5) The starboard recip engine selector was in the on position.

"SPECIAL HANDLING REQUIRED IN ACCOMDANCE WITH OPNAV INSTRUCTION 3750.6D"

- (6) The port recip main fuel tank selector was in the off position.
- The starboard recip main fuel tank selector was in the open position.
 - (8) The port Hydraulic/Oil valve was not recovered.
 - (9) The starboard hydraulic/oil valve was in the closed position.
 - (10) The port jet actuator was in the 100% position.
 - (11) The starboard jet actuator was in 100% position.
- (12) The gross weight at the time of the accident was approximately 65,000 lbs.
 - e. The DIR's of the jet and reciprocating engines indicated that:
- (1) The jet engines were operating at an indeterminate RPM upon impact with the trees.
- (2) The salvagable portions of the reciprocating engines indicated no discrepancy concerning the port engine, nor could the starboard engine malfunction be determined. The starboard engine was developing an indeterminate amount
- f. The PPC, LT McHUGH had a total of 1612 flight hours, 1053 of which were in P2V-5/5FS and 41 hours in P2V-3/4 types of aircraft. He had been a designated
- g. LT BROUGHTON had a total of 3058 flight hours, 344 P2V-5/5FS hours and 74 P2V-2/3 hours. He held a PP3P designation.
- h. The plane captain, an ADR3, had been designated since May 1962 and had 520 hours in the P2V-5FS. He was located aft of the pilots upon impact.
- i. The wheels and flaps were up at the time of impact. Where the flaps were raised could not be determined.
- j. Two crash fire fighters, wearing aluminumized asbestos suits were detached from a rescue helicopter approximately & mile from the crash site. One of the men died of heat exhaustion prior to reaching the site. The other suffered heat exhaustion, became unconscious and did not reach the site until approximately two hours after the crash.
- 3. The cause of the accident was personnel error in that the port engine propeller was feathered when a malfunction existed in the starboard segine. The jets were lighted, however insufficient altitude existed to permit

"SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH OPNAV INSTRUCTION 3750.6D"

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NASC/60/ed Ser: 1878 20 August 1962

acceleration to stop the rate of descent which had been initiated when the port engine was feathered. Whether altitude was being maintained on the port engine prior to its feathering is not known, however, the P2V-5F Flight Manual states that "a wave-off at any normal landing weight can be made with Military Power on the good reciprocating engine and 100% RPM on the jet engine. At high landing weights, both jets should be utilized." Also, "The possibility of a wave-off is present on any landing, but on a single engine landing a waveoff is more critical. The decision to take a wave-off should be made as early as possible on the final approach. Do not attempt to go around unless conditions are ideal (light airplane, day WFR conditions, level terrain and good engine operating normally)."

4. Recommendations:

- a. In view of the above it is recommended that the Chief of Naval Operations add to the applicable P2V NATOPS manuals the following: Jet engines will be placed in "IDLE" on all landing approaches and, secured on touchdown. On approaches where a wave-off is anticipated, such as GCA practice, the jet engines will be at idle. It is recognized that this may increase foreign object damage but this is considered an acceptable risk when the safety of the entire aircraft is at stake.
- b. That wide publicity from all sources be given to the possibility of heat exhaustion in the wearing of crash fire-fighting protective clothing for great lengths of time while very active physically, and while in high temperature/humidity areas.

c. Proper handling of emergencies with emphasis placed on feathering will continue to be stressed by the Naval Aviation Safety Center.

Acting

Copy to: CNO (orig. & 5) BUWEPS (5 copies) COMNAVAIRLANT COMNAVATRPAC CNATRA CNAVARTRA CNARESTRA COMASWFORLANT COMFIRWINGSLANT COMPAWWING 11 VP-16 NAS GLYNCO

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26. DESCRIPTION OF FINDINGS:

- A. EXAMINATION PRIOR TO DISASSEMBLY REVEALED THAT THE NO. 3 BLADE HAD TORN FROM THE HUB SOCKET AS SHOWN BY ENCLOSURE (1).
 - B. THE NO. 1 BLADE HAD BROKEN APPROXIMATELY TWO FEET OUTBOARD OF THE CUFF.
- C. THE NO. 2 BLADE HAD BROKEN AT THE SAME LOCATION AND BENT AFT JUST OUTBOARD OF THE GUFF AS SHOWN.
 - D. THE NO. 4 BLADE HAD BROKEN AT THE 66 INCH STATION.
- E. THE TEETH WERE SHEARED FROM THE ROTATING CAM GEAR AT FOUR LOCATIONS AS SHOWN.
- F. THE ROTATING CAM GEAR UPON REMOVAL OF THE DOME, WAS FOUND TO BE IN THE LOW PITCH POSITION.
 - G. NO OTHER DISCREPANCIES WERE FOUND.

27. CONCLUSIONS:

IT IS CONCLUDED THAT THE PROPELLER WAS ROTATING UNDER POWER IN LOW PITCH AT TIME OF IMPACT.

28. RECOMMENDATIONS:

NONE.

ENCL: (1) NAS NORVA PHOTO



O&R DEPT NAS NO	6. ASSEMBLY (SEE	97	8/1/62 7. ASSEMBLY MFR	GOV EL	RNOR	PRO	PELLER	5U18-	47P1		ENG
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26. DESCRIPTION OF FINDINGS:

- A. EXAMINATION PRIOR TO DISASSEMBLY DISCLOSED THAT ALL FOUR BLADES HAD BENT AT APPROXIMATELY THE 66 INCH STATION AS SHOWN BY ENCLOSURE (1).
 - B. BLADE DAMAGE OTHER THAN BENDING WAS CONFINED TO THE LEADING EDGE.
- C. REMOVAL OF THE DOME ASSEMBLY AND EXAMINATION OF THE ROTATING CAM GEAR DAMAGE INDICATED THE PROPELLER WAS IN FULL FEATHER AT IMPACT, AS SHOWN BY ENCLOSURE (2).
- D. EXAMINATION OF THE BLADES DISCLOSED THAT BLADES 3 AND 4 SHEARED THE TEETH FROM THE ROTATING CAM GEAR AND WENT TOWARD LOW PITCH PRIOR TO BENDING AFT, AS SHOWN.
- E. THE NO. 1 AND 2 BLADE HAD TWISTED BEYOND THE FEATHER POSITION AND BENT AFT.
 - F. NO OTHER DISCREPANCIES WERE FOUND.

27. CONCLUSIONS:

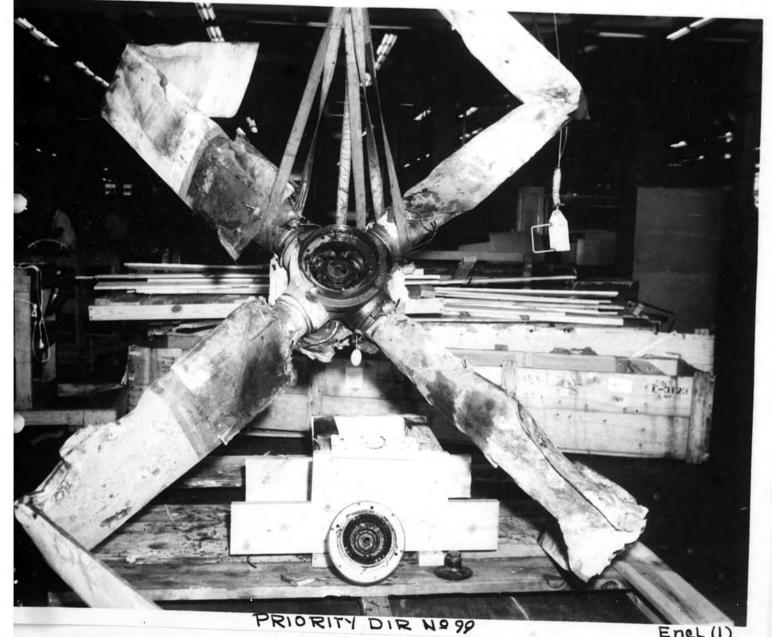
IT IS CONCLUDED THAT THE PROPELLER WAS FULLY FEATHERED AT IMPACT AND DUE TO THE BENDING FOUND ON ALL FOUR BLADES WAS APPARENTLY ROTATING SLIGHTLY.

28. RECOMMENDATIONS:

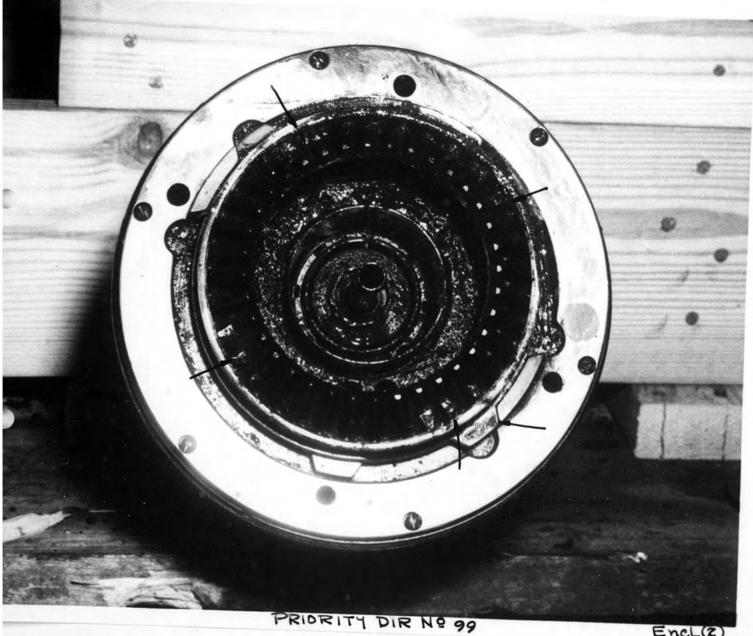
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ENCL: (1) NAS NORVA PHOTO

(2) NAS NORVA PHOTO



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OSR DEPT NAS NORVA PRIORITY DIR NO. 96 8 AUGUST 1962

26. DESCRIPTION OF FINDINGS:

MOST ALL MAGNESIUM AND ALUMINUM COMPONENTS OF THE ENGINE WERE DESTROYED BY FIRE AFTER IMPACT, SUCH AS THE CRANKCASE FRONT SECTION, SUPERCHARGER FRONT HOUSING, SUPERCHARGER REAR HOUSING, FRONT OIL SUMP, REAR OIL SUMP, INTAKE PIPES, IGNITION HARNESS, CARBURETOR, MAGNETO, DISTRIBUTORS, PISTONS AND CYLINDER HEADS. TWENTY-FOUR VALVES WERE ACCOUNTED FOR AND THERE WERE NO INDICATIONS OF A VALVE FAILURE PRIOR TO IMPACT AMONG THESE VALVES. THE HEAD HAD BEEN BURNED OFF ONE EXHAUST VALVE AND THE STEM HAD BEEN BURNED OFF ANOTHER VALVE. THE STELLITE HAD BEEN BURNED OFF SEVERAL OF THE VALVE FACES. EXAMINATION OF THE PISTON RINGS LEFT FUSED TO THE CYLINDER WALLS INDICATED THERE HAD BEEN NO PISTON NOR PISTON RING FAILURE PRIOR TO THE CRASH. THE ACCESSORY DRIVE AND STARTER SHAFT WAS BURNED INTO APPROXIMATELY SIX INCHES FROM THE SPLINED END. INSPECTION OF THE IMPELLER DRIVE GEAR TRAIN DID NOT REVEAL ANY COMPONENT FAILURES. THERE WAS NO SCORING PRESENT ON ANY OF THE BEARINGS AND BUSHINGS THAT WERE RECOVERED. NOR WAS THERE ANY INDICATION OF A MASTER ROD BEARING FAILURE. NONE OF THE ARTICU-LATED RODS WERE BROKEN. THE PROPELLER SHAFT WAS SHEARED APPROXIMATELY TEN INCHES FROM THE FLANGED END DUE TO IMPACT. INSPECTION OF THE TWO POWER RECOVERY TURBINES RECEIVED DID NOT REVEAL ANY EVIDENCE OF A FAILURE NOR PASSAGE OF FOREIGN OBJECT OR OBJECTS.

27. CONCLUSIONS:

INVESTIGATION OF THE ENGINE WHICH WAS REMOVED FROM THE PORT POSITION OF THE AIRCRAFT DID NOT DISCLOSE ANY EVIDENCE OF OIL STARVATION, ENGINE MALFUNCTIONING AND/OR ENGINE COMPONENT FAILURE PRIOR TO THE CRASH. INVESTIGATION OF THE BURNED VALVES REVEALED THEY HAD BEEN BURNED DUE TO THE EXTENSIVE HEAT FROM THE MAGNESIUM FIRE AFTER IMPACT.

28. RECOMMENDATIONS:

NONE.

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Q&R DEPT NAS NORVA _ _ PRIQRITY DIR NO. 94 _ _ _ 6 AUGUST 1962 _ 26. DESCRIPTION OF FINDINGS:

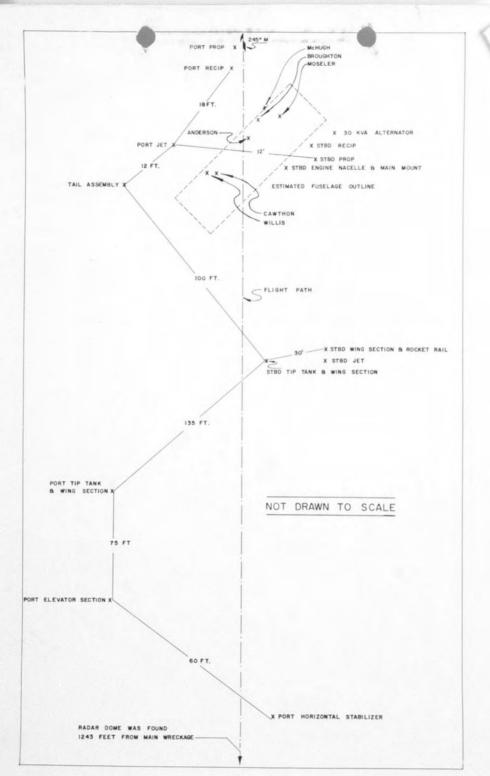
MOST ALL MAGNESIUM AND ALUMINUM COMPONENTS OF THE ENGINE WERE DESTROYED BY FIRE. ALL THE CYLINDER HEADS WERE DESTROYED BY FIRE EXCEPT FOR THE NUMBER 1, 15, 16, 17 AND 18 CYLINDER HEADS. ALL THE INTAKE AND EXHAUST VALVES WERE ACCOUNTED FOR AND WERE FOUND TO BE SATISFACTORY. EXAMINATION OF PISTONS AND PISTON RINGS NOT DESTROYED INDICATED THERE HAD NOT BEEN EITHER A PISTON OR PISTON RING FAILURE. THE MAJORITY OF THE PISTONS WERE DESTROYED BY FIRE LEAVING THEIR RESPECTIVE PISTON RINGS FUSED TO THE CYLINDER WALLS. THERE WAS NO SCORING PRESENT ON ANY OF THE BEARINGS AND BUSHINGS RECOVERED, NOR WAS THERE ANY INDICATIONS OF A MASTER ROD BEARING FAILURE. EXAMINATION OF THE ARTICU-LATED RODS REVEALED NONE TO BE BROKEN OR BENT. INSPECTION OF THE IMPELLER DRIVE GEAR TRAIN REVEALED NO EVIDENCE OF A FAILURE. THE PROPELLER SHAFT WAS SHEARED APPROXIMATELY 10 INCHES FROM THE FLANGED END DUE TO CRASH IMPACT. THE ENGINE ACCESSORIES WERE EITHER DESTROYED BY FIRE OR DUE TO EXTENSIVE FIRE DAMAGE NO CONCLUSIVE RESULTS COULD BE OBTAINED. HOWEVER THE MANUAL MIXTURE CONTROL ON THE REMAINING PORTION OF THE CARBURETOR WAS IN THE IDLE CUT-OFF POSITION. INSPECTION OF THE POWER RECOVERY TURBINES REVEALED NO EVIDENCE OF A FAILURE OR PASSAGE OF FOREIGN OBJECT OR OBJECTS.

27. CONCLUSIONS:

INVESTIGATION OF THE ABOVE ENGINE WHICH WAS REMOVED FROM THE STARBOARD POSITION OF THE AIRCRAFT DID NOT DISCLOSE ANY EVIDENCE OF OIL STARVATION, ENGINE MALFUNCTION AND/OR COMPONENT FAILURE. THE POSITION OF THE CARBURETOR MANUAL MIXTURE CONTROL IS NOT SIGNIFICANT AS IT COULD HAVE BEEN A RESULT OF

28. RECOMMENDATIONS:

NONE .



TRANSCRIPT OF GCA UNIT TAPE RECORDING OF LAST APPROACH OF SPANGLE 12 (BUNO 131441) ON 23 JULY 1962.

GCA: Spangle 12, Your Student Controller, if runway not in sight at minimums, climb to and maintain 1,500 immediately and stand by for further clearance. Acknowledge.

Spangle 12: Roger, 12.

GCA: Spangle 12, Maintain, correction, turn left, maintain 1,100, you's in left turn, your 10 second gear warning at this time, approaching glide path. Set up your normal rate of descent, stop your turn, below glide path coming up, slightly below glide path, very slightly below glide path, coming up and on glide path, four miles from touchdown, on glide path, on glide path. Outside observer holds you visual contact. You are going above glide path, slightly above glide path, slightly above glide path, slightly above glide path, turn right, slightly above glide path in a right turn, coming down now, stop your right turn, check wheels down and locked. Acknowledge.

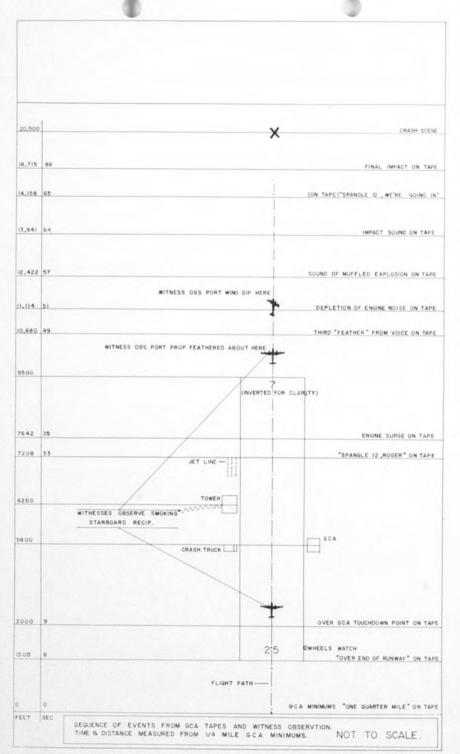
:12: Gear down and locked.

GCA: Spangle 12, Roger, you are slightly above glide path. Three miles from touchdown, slightly above, slightly above glide path and holding, slightly above glide path, maintain your present heading, slightly above glide path and holding. Slightly above, 21 miles from touchdown, the tower clears you for a low pass. Surface winds WSW 6. You are slightly above glide path coming down now, slightly above, very slightly above and holding, very slightly above and holding, two miles from touchdown, turn left. You are very slightly above glide path in a left turn, stop your turn, very slightly above glide path and holding. You are very slightly above glide path and holding, very slightly above and holding, very slightly above glide path and holding. Maintain your present heading 12 miles from touchdown, you are very slightly above glide path and holding. Now turn right, in a right turn, stop your turn, very slightly above and holding, coming down now on glide path, one mile from touchdown, approaching minimums. Pop yourhood, you are on glide path, on glide path, now turn right, on glide path, stop your turn, on glide path, on glide path, 1 mile from touchdown, on glide path, on glide path now; turn left, stop your turn, 1/4 mile at precision minimums. Take over visually centerline directly ahead, observe you leveling off as you pass over end of runway. On course over GCA touchdown. Upon completion of your low pass continue straight across the field, climb to 500 feet, GCA over.

12: GCA this is Spangle 12.... Feather it! Feather it! Feather We're going in, this is Spangle 12.

GCA: Go ahead, Spangle 12, Glynco GCA.

DATE OF ACCIDENT 23 JULY 1962 LOCAT GLYNCO, GEORGIA TYPE OF AIRCRAFT P2V-5FS BUNO# 131441 AIR ACCIDENT REPORT NUMBER 1-62



STATEMENT OF (b) (6) AC1, (b) (6)

I have worked in control towers for about two years. I have held a senior controllers certificate since November of 1961.

I was section leader in the tower at the time of the crash, supervising the approach control and local control positions. Spangle 12 was making a GCA low pass to runway 25. Approach control had two T2V's, one making a UHF ADF approach and one making a T-4 approach. I looked up from the approach control position and saw Spangle 12 a little past mid field; his starboard jet appeared to me to be smoking. Round spurts almost like smoke rings. I grabbed a pair of binoculars to check the aircraft. When Spangle 12 was about over the numbers, west end of the runway, at about 200 feet altitude, I observed #1 engine, port side, being feathered and come to a complete stop. I immediately set off the crash phone. The left wing dipped slightly. I turned toward the crash phone and when I looked back the P2V had disappeared. About 20 to 30 seconds later I observed a ball of fire that appeared to rise about 300 feet or more. The time I first observed this was 1043(R); I saw the fireball at 1045(R).



(b) (6)
STATEMENT OF

ACC, (b) (6)

I am the leading chief of the GCA Unit 32 stationed at MAS Glynco, Georgia. I have worked with GCA units for about six years and as an Aviation Machinist Mate prior to that for about sixteen years. At about 1035(R) on 23 July 1962 I was in the GCA lounge trailer listening to the practice approaches of Spangle 12. I heard Spangle 12 passing over the trailer on GCA wave off with an apparent rough running reciprocating engine. The engine sounded like it was cutting in and out. On hearing the rough running engine, I jumped up and looked out the window facing west and saw that the starboard reciprocating engine was smoking badly (black smoke) with intermittent flames coming out from around the cowl flaps. From my vantage point I had a clear, unostructed view of the starboard side of Spangle 12. At this time the aircraft was about 3000 feet from the upwind end of runway 25 at about 200 to 250 feet of altitude. The landing gear was up at this time. Just as the aircraft approached the upwind end of runway 25 a big ball of flame came out of the top of the starboard reciprocating engine and the aircraft veered 10 degrees to the left in a very shallow bank. The aircraft then leveled its wings and descended in a shallow glide. When I saw the smoke coming from the engine I advised the tower to alert the crash crew. From the sound of the aircraft I believe Spangle 12's jet engines were not running as he passed over the GCA trailer.

STATEMENT OF (b) (6)
AC1, (b) (6)

I am a final approach controller attached to GCA Unit #32, at NAS Glynco, Georgia. I've been working with GCA for about one year and as an air controller for approximately 14 years. At about 1030 local on 23 Jul 1962, I was outside observer at the GCA unit. I had observed all of Spangle 12's previous approaches. At this time, Spangle 12 was on his fourth approach to runway 25. I had visual contact with Spangle 12 from 6 miles on final throughout the approach and waveoff. I was looking out the windows on the east side of the lounge trailer and observed the P2V level off as he was notified he was over GCA touchdown and saw his wheels come up and go into the wheel wells. The wave off looked normal and he had made an excellent GCA approach. He was out of my sight for about five seconds as he passed over the trailer. Chief (b) (6) said his engine sounded rough and I opened the door on the west side of the trailer and stepped out onto the first step. I noticed a slight trail of dark blue or black smoke from the starboard engine which got heavier as he proceeded down the runway. I did not notice any fire until he was about over the upwind end of runway 25. I had a clear view of the starboard side of Spangle 12 after it passed the GCA shack untilift went out of sight behind the trees. As Spangle 12 passed over upwind end of runway 25, I noticed a good sized burst of flame come out of the top side of the starboard engine. Just after this the plane made a slight turn to the left with no noticeable

bank. Soon after this I heard, "I'm going in, this is Spangle 12" over the radio. After Spangle 12 disappeared behind the trees, I saw a big mushroom of dark orange flames (a ball of flame) and black smoke. It went well above the trees. I observed the starboard prop turning very slowly before he went out of sight. The prop did not appear to be spinning at a constant speed but seemed to be intermittently slowing down and speeding up. After hearing another P2V making a waveoff from GCA with jets, I definitely feel that Spangle 12 was not using this jets as he passed over the GCA trailer on wave off.

(b) (6

STATEMENT OF (b) (6) AN, (b) (6)

I am assigned to the crash crew at NAS Glynco, Georgia. I have performed duty as a member of the crash crew for about a year.

On 23 July I was standing by in an MB-5 crash truck, parked adjacent to the runway, about halfway down the way. I first noticed this P2V about 2000 feet west of the landing end of the runway. I saw that the right engine (recip) was smoking and missing. As he flew by me he looked slower than other P2V passes I had seen. From the sound the aircraft made the jets were not running as he passed by me. I could see as he flew towards me that his jet doors were closed. After he flew past me the amount of smoke increased and came out in a steady stream. After he passed the runway he turned to the left slightly and started going down. Then he seemed to stop turning and kept going down. I saw him go into the trees and then saw a big ball of smoke and flame.

(b) (6)

STATEMENT OF (b) (6)

on July 23, 1962, around 1030 I heard a noise that sounded like a recip motor missing. I was standing in back of an F3D on the back line at the time, approximately at the 2000 foot marker from the west end of the runway. When I looked up I saw a P2V come over the runway about 200 feet above the runway. The starboard engine was coughing black smoke. I did not see any fire in the engine. The P2V seemed to be holding the altitude that it was at until it started to turn into the port engine, west of the runway. At about the same time the starboard engine quit popping and belching smoke. After the P2V started to turn into the port engine it started to lose altitude. I kept waiting to hear the jet engines light off, but as far as I could tell they never did. As soon as the P2V started to lose altitude while in a left turn, the aircraft leveled out and then disappeared into the trees. I heard no explosion of any kind other than the noise that the motor was making going over the field.

I have been connected with naval aviation since March 26, 1962. I have been flying for nine years in private aircraft, but I am not a pilot.

I was located about 3/4 of the way down the jet line, toward the west end. I heard the P2V as it approached the east end of the runway. I 1 looked up about the time an engine coughed twice. I estimate the aircraft altitude to be 150 - 200 feet high when it was approximately 1000 feet from the approach of runway 25. After coughing two times the engine seemed to smooth out and was running fine, still holding the same altitude. On neither cough did smoke emit from the engine. The aircraft was clean in configuration all the time it was possible for me to see clearly. I noticed no increase in power of either engine. As the aircraft neared the 2000-foot markers on the west end of the runway the starboard engine started coughing rapidly; following each cough a blackish-gray cloud of smoke would come off the engine. At this time I climbed upontthe tail of an F3D aircraft for a better view (approximately 12 feet high). I remember hearing the jet engines or engine trying to light off. The engines or engine (jet) may have reached idle RPM but no faster. I don't believe the power on the port engine was ever increased; however, the aircraft was veering slightly to port, with port wing slightly down. About this time he started losing altitude rapidly. I don't recall hearing the starboard engine (recip) cough or seeing it smoke at this time. I couldn't say if it was feathered or secured as the aircraft was too far away to tell. It was still clean in configuration. As the aircraft went down below the trees I could hear it for a second or two then I saw this tremendous ball of flame about 100-150 feet high (est.), followed by smoke. I heard no noise, only flame and smoke. I forgot to mention that the smoke following each cough seemed to come from the top of the engine (starboard

recip), and when I saw the aircraft from the front the jet doors were closed. I am a line trouble shooter. Have been in the Navy about two years and two months. I have been working around aircraft about $1\frac{1}{2}$ years.

(b) (6)

STATEMENT OF (b) (6) USMC

I am a naval aviator with about 2200 hours flight experience, assigned to NATTC at NAS Glynco.

At approximately 1040 hours on 23 July 1962 I was preflighting an F3D aircraft for a planned local flight out of NAS Glynco, Georgia. While under the wing of the aircraft I heard a reciprocal engine malfunctioning, missing rather than a complete power failure. The aircraft sounded like it was executing a low pass over the field. AEAN (b) (6) plane captain for my aircraft, called to me saying the aircraft was in trouble and was "going in". I ran to the rear of my aircraft to see the troubled aircraft. I saw a P2V aircraft at approximately 300 feet in level flight proceeding to the field boundaries on a heading of about 250° magnetic. The aircraft held altitude and level flight for several seconds and then began to settle. There were no signs of exterior trouble, that is smoke, flying parts, trailing landing gear, etc., from the first time I saw the P2V until the last time I saw it. The P2V continued to settle holding level flight. The attitude was good for ditching all the way until disappearing behind the line of trees to the west of the field. As the P2V settled out of sight, I heard the jet engines, sounded like F3D with both engines, turning up at maximum RPM. I do not recall hearing the jet engines operating on the P2V passed over the field. I did not hear the jet engines start up. I did not see either reciprocating engine in a feathered condition as the P2 V was too far away to notice the props. It did appear that both props were turning. The P2V settled out of sight and a few seconds later a large black cloud rose above the trees.

ACC, (b) (6)

I have been an air controller for twelve years. On the morning of 23 July 1962 I was working in the tower at NAS Glynco, Georgia.

At approximately 1043(R) Spangle 12 made a low pass on runway 25 on GCA frequency. His altitude appeared to be about 200 feet. About 6000 feet down the runway (25) I observed puffs of black smoke coming from the starboard side of the aircraft. The puffs continued at regular intervals and appeared from the jet on the starboard side. The aircraft appeared to climb to three or four hundred feet, turn slightly left, left wing down slightly and begin to settle. His glide was very shallow and looked as if he would recover. Crash circuit was opened and reported as a crash while the aircraft was approximately 100 feet above the tree line. He disappeared behind the tree line to the west edge of the field. A large ball of fire was observed, followed by a column of black smoke. All crash equipment was dispatched immediately.

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DESCRIPTION OF DIFFICULTIES IN FIRE CONTROL AND EXTINGUISHMENT DUE TO UNUSUAL CONDITIONS OR EQUIPMENT AND/OR AGENT INADEQUACIES

The progress of all equipment was hampered by the unusually heavy undergrowth encountered at the crash scene, and the rapidly spreading fire through the underbrush. Only one piece of equipment (MB-1) was able to get close enough to the crash scene to discharge its foam. As men arrived they were put to work beating out brush fires with pine limbs until a supply of CO₂, shovels and brush beaters arrived. The MB-1 suffered extensive damage in traversing the area.

RECOMMENDATIONS FOR IMPROVEMENTS IN EQUIPMENT AND/OR PROCEDURES TO INCREASE EFFICIENCY

Mayal Air Stations located in areas of inaccessible terrain should have special equipment for fire fighting and rescue. Heavy lift helicopter is required that has fire fighting and rescue erew capability. The terrain surrounding NAS Clynco is a wide expanse of timber, palmetto, and swamplands, with few if any egress roads. The only positive method of transportation is via helicopter.

Imaediate area	MONETARY LOSSES (Estimated)	MOING PROPERTY
23 Jul 62 PREPARED (b)	coe, USN (b) (6)	O.M.
23 Jul 62 STATION COMMENT	W. EARLY, CAPT, USN	
,	, war, ush	V

HELICOPTER RESCUE REPORT OPNAY FORM 3750-12 (REV. 4-59)

INSTRUCTIONS: 1. Mail original and one copy direct to NASC

and one copy direct to CNO.

Report will be submitted within five working days of rescue or attempted rescue.

3. Serialize by calendar year (e.g., first report

4. Use local time.
5. If exact data is unknown such as time, temperature, etc. give approximate data.
6. Enclosures will be appended to the report if the statement will amplify the data on the form (e.g., Survivor had difficulty due to insufficient training.
7. Refer to the effective edition of OPNAVINST 3750.6

FROM: COMMA							REP	ORT DATE	Jul 1	962		1000	RT SERIAL NO.		
	der, U.S. I	Naval Av	iation S					HRS-		BUN	901		OPERATIN	Glyno	00
DATE OF EMERGENCE 23 Jul	Y	100	local)	Loc		EMERGENO		of N	AS GL	yneo					
TIME AND METHOD OF NOTIFICATION OF EMERGENCY 1035 Glynco Crash Circuit			TIM	104	IVAL AT S	CENE	"	-	tual resc	total ELAPSED FLIGHT TIME 1 hr 30 min					
HELICOPTER RESCUE PERSONNEL RANK, NAME - LAST, FIRST, MIDDLE INITIAL RATE		Si	ERVICE/I	FILE NO.	E NO. RESQUE INSTRI		FORMAL S		AL SCHOOL	SOHOOL ATTENDED		K-UPS			
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PILOT'S STATEMENT	SURVIVOR'S STATEMENT (indicate number, if more than one)	(b) (6) CDR.	USN
		By direction ENC	OCHE L

move crews and firefighting equipment into inaccessible areas.

LIST OF ENCLOSURES

- 1. Autopsy Report on LT Philip R. McHugh USN
- 2. Autopsy Report on LT James A. Broughton USN
- 3. Autopsy Report on ANDERSON, Ronald W., ADR3 USN
- 4. Autopsy Report on CAWTHON, James V., ATCA USN
- 5. Autopsy Report on MOSELER, Kenneth J., AE2 USN
- 6. Autopsy Report on WILLIS, Harry C., ADR3 USN
- 7. The Tape
- 8. Statement of LT (b) (6)
- Statement of (D) (6)
- 10. Statement of (b) (6) AC1 USN
- 11. Statement of (b) (6)
- 12. Statement of (b) (6)
 ACI USN
- 13. Statement of (b) (6) AN USN
- 14. Statement of (b) (6)
- 15. Statement of (b) (6)
- 16. Statement of (b) (6)
- 17. Statement of (b) (6)
- 18. Part VIII of the AAR The Analysis
- 19. Comments and Recommendations
- 20. Part IX of the AAR Recommendations
- 21. Wreckage Distribution Diagram
- 22. Sequence of Events Diagram
- 23. Fuel System Diagram
- 24. Photographs (6)

I AM (b) (6)

AG2 (b) (6)

USN U.S. NAVAL AIR STATION
1962 TO 1900 23 JULY 1962.

THE FOLLOWING IS MY STATEMENT OF THE WEATHER CONDITIONS PREVAILING AT THE U.S. NAVAL AIR STATION GLYNCO, GEORGIA AT 1032 HOURS 23 JULY 1962.

SKY CONDITION

VISIBILITY
SEA LEVEL PRESSURE
STATION PRESSURE
AIR TEMPERATURE
DEW POINT TEMPERATURE
RELATIVE HUMIDITY
SURFACE WIND
STATE OF GROUND

7 TENTHS CUMULUS CLOUDS AT AN ESTIMATED 2,000 FEET. 7 MILES 30.053 INCHES (1017.7 MB) 30.021 INCHES 88 DEGREES F. 77 DEGREES F. 71% WEST SOUTH WEST 6 KNOTS DRY

(b) (6)
AG1, USN

(b) (6)

AG2, USN

23 JULY 1962 DATE SIGNED

DSH054 SDG 032 PP RUCKSH DE RUCKDG 832 P 071515Z FM NAS NORVA TO PATRON SIXTEEN INFO ZENZNAVAVNSAFECEN ZEN/COMNAVAIRLANT COMFAIRWINGSLANT COMFAIRWING ELEVEN ZEN/BUWEPSFLTREADREPLANT

PRIORITY INVES ENGS PROFS FROM CRASMED PRV-5FS BUNG 131441

A. PATRON SIXTEEN 341539Z 1. RESULTS OF PRELIMINARY INVESTOF ENGS PROPS FOLLOWS:

A. STARBOARD ENG SER NR 552840 NO DISCREPANCIES NOT ATTRIBUTED TO CRASH AND FIRE. NO EVIDENCE OF OIL STARVATION. CARBURETOR MANUAL

MIXTURE CONTROL IN IDLE CUTOFF. B. PORT ENGINE SER NR 563480 NO DISCREPANCIES EXCEPT SOME BURNED VALVES. VALVES DELIVERED TO LOCAL MATERIALS LABORATORY FOR ANALYSIS. NO EVIDENCE OF OIL STARVATION. CARBURETOR MANUAL MIXTURE CONTROL

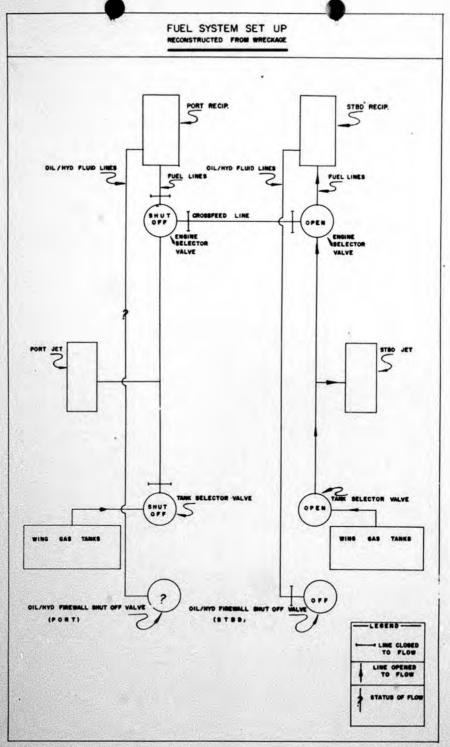
JUST OUT OF NORMAL DETENT. POS. TION NOT CONSIDERED SIGNIFICANT. C. PORT PROPELLER GOVERNOR SER 83941 ELECTRIC HEAD FOUND TO BE SET AT TAKE OFF RPN. IMPOSSIBLE TO DETERMINE IF FEATHERING SYSTEM ACTUATED.

D. PORT PROPELLER SER NR N 163032 DOME SETTING FULL FEATHER AT TIME OF IMPACT. PROP ROTATING SLOWLY. NO INDICATED MALFUNCTION. E. STARBOARD PROPELLER SER NO N 178592 DOME SETTING FULL LOW PITCH AT IMPACT. NO REASON FOUND PROP. COULD NOT BE FEATHERED. PROP

ROTATING UNDER POWER AT IMPACT. F. BOTH PROP SHAFTS FAILED FROM BENDING.

2. DIR'S WILL FOLLOW.

Ø7/1515Z



J 34 WESTINGHOUSE TURBO-JET ENGINE BULLETINS NOT INCORPORATED LIST

Port Ser 200655 Publication No.	Starboard Ser 201614 Publication No.	Title
266A-1	266A-1	THREADED PINS 31H11-1; for retaining
	279	the diffuser extension RETA INING NUT: Modification Turbine
		61H197-1
300A-1	291A 300A-1	GEARBOX DRIVE SPLINES; lubrication of THERMOCOUPLE CABLE HOLDING BRACKET; (26G845-1)
306		HIGH ENERGY IGNITION UNIT: SNT10-75000.
312	312	4 WXT 60E732-3 BEARING HOUSINGS NO. 2&3; modification
322A-2	322A-2	of COMPRESSOR ROTORS; inspection and repair of
323A-2	323A-2	COMPRESSOR ROTORS; inspection and repair of
324A-1	32LA-2	COMPRESSOR ROTOR ASSYS 13J966-9, 13J977
328 - 1 330	328-1	6 & 43J463-9; modification to or use ACCESSORY GEARBOX HOUSING 43J754-3 STARTER CLUTCH SHAFT 61F364-1; inspec-
331-2	331-2	tion & modification POWER TAKEOFF ASSYS 19E684-456. mod
332	332	ification to COMP.ESSOR BOSS COVERS; 106T988-use of
333 - 1 334	333-1 334	SEAL HOUSING; method of drilling slots BEARING HOUSINGS Nrs 2 &3 (22E91=9 &
	335A	19E904-9) mod to and use of LUBRICATING SYSTEM; operating temperature
336-1	336-1	& oil pressure curves TURBINE ROTOR ASSY; 22E273-11, modifica-
338A	338A	tion to
339	339	"T" NUMBER PARTS AND DRAWINGS; index of TURBINE; blades-reinspection of spare stock
340-1 341-1	340-1	ORIFICE TEE; installation of WXT 107T50
345	341-1 345	LOCKRING; rosan, replacement of LOCKPLATES AND TARWASHERS; in specific
348	348	locations, installation of CALIBRATION NOZZIE (243203); rework to
351-1	351-1	enlarge exit area of FUEL CONTROLS(Holley 5805 Series): mod-
352	352	P.T.O. GEAR BOX; minimum axial clearance. P.T.O. gear box to vompressor rotor
-354-1	354-1	spline adapter control of TURBINE BIADES; replacement and time
355B	355B	coding NO.1 BEARING; replacement of
360	360	SETSCREW 1st stage nozzle inner shroud, replacement of

Port Ser 200655 Publication No.	Starboard Ser 201614 Publication No.	Title
361		TITTE
365	365	FUEL CONTROL FILTER; replacement
367-1	367-1	instr for manin and NOZZLE ASSEMBLIES:
369	369	ENGINE ACCESSORY RECORD NavAer 418A-1 use of DUMP VALVE SEAT; replacement of
Note: The publica		replacement of

Note: The publication numbers that are underlined indicates the portion of the bulletin that had been complied with.

GENERAL GAS TURBINE ENGINE BULLETINS NOT INCORPORATED LIST

Port Engine Ser No. 200655	Starboard Engine Ser No. 201614	Title
30	30	
33	33	D27(E-2) STARTER FOR USE WITH HEMIS- PHERICAL CAP; modification of STARTER: Jack & Heintz modification cleaning & zirc about modification
43A	43A	starter Bases chromate processing
62	62	STARTER: Jack & heintz D27-1/D27-48 modification DATA DECALCOMENTA: Dance
ENERAL RECIPROCA	ATING ENGINE BULLETING	DATA DECALCOMANIA; Performance opera- ting limitations

GENERAL RECIPROCATING ENGINE BULLETINS NOT INCORPORATED LIST

Port Engine Ser No. 563482	Starboard Engine Ser No. 560840	Ti+10	
213	213	Title	
271.	213	PROTECTIVE COATING FOR ENGINE FARTS;	
214	214	instruction for application of	
Doors -		haul instr	
R3350 WRIGHT ENGI	INE BULLETING NOW THE		

R3350 WRIGHT ENGINE DULLETINS NOT INCORPORATED LIST

Port Ser 563482 Publication No.	Starboard Ser 562	TORATED LIST
412	TOTAL NO.	Title
416-1		CARBURATORS: Chandler Evans Model 58- CPB11 Bottom Drop Replacement WATER INJECTION POWER CONTROL UNIT;
464A		feature from of high clutch
468-1	468-1	GENERATOR DRIVE GEAR BUSING; Provision of steel backed, silver plated
502	502	OIL SEAL RING; Stationary reduction gear torque indicator support, provision POWER RECOVERY TURBINE; Nozzle Pylon Support Brace
		FNCI OCUM-

Port Ser 563482 Publication No.	S board Ser 562840 Publication No.	Title
	505-1	POWER RECOVERY WHEEL; with reduced
517-1	517-1	diameter POWER RECOVERY TURBINE SHAFT OIL SHAFT
51.8 570-1	51.8	FRI; through bolt attachment CARBURATOR BELLOWS CASE: Chandler
622A		OIL PUMP DRIVE GEAR WITH SEPARATE
<u>635</u> 8		1. POWER RECOVERY TURBINE PRIMARY DRIVE & FLUID COUPLING SUPPORT 2. SPOT-FACING OF POWER RECOVERY TURBINE FLUID COUPLING SUPPORT 3. USED OF SAISTY WIRE IN PLACE OF
553-1 674A-2	671A-2	FRONT OLL PUMP AND SUMP MAGNETO, Bendix-Scintilla Model DIN-9
691-1	685 691-1.	replaceable rear bearing support PROPELLER SHAFT INTAKE PIPE CONNECTOR; Rear cylinder
	697 699	DISTRIBUTION SHIELD CONDUIT DISTRIBUTION HOUSING, BENDIX SCINTILLA
700 705 706 707	700 705 706 707	P/N 10-55287Y & 1080681 WATER INJECTION POWER CONTROL ASS'Y SILASTIC MATERIAL ON CYLINDER INTERNAL PORQUEMENTER OIL LINE PACKING RING, FRONT & REAR THREADED
708	703	INTAKE PIPE CONNECTOR CRANKCASE MAIN SECTION OIL DISTRIBUT-
	709 711	GENERATOR CRIVE OIL SEAL IMPELLER DRIVE; secondary inner and
714-1 716-1 717 718	711;-1 716-1 717	outer pinion shafts CYLINDER AND PISTON ASSEMBLIES CRANKCASE MAIN SECTION CAM, FRONT INTAKE & EXHAUST DISTRIBUTOR COLLECTOR & HARNESS CON-
720		NECTION PLATES VALVES SPRINGS; rework of raduis on last coil of inner and outer, and
721	721	PISTON REPLACEMENT, INSPECTION AND
722 726	722 726	RECONDITIONING VALVE, PRE-OIL AIR BLEED IMPELLER DRIVE SECONDARY PINION CARRIER SUPPORT

Note: The publication numbers that are underlined indicates the portion of the bulletin that had been complied with.

1 FROM / Name and a	nailing address of act	TU	SE	CTION A - IDE	NTIFICA	TION	SHE				TOTAL CONTRACT
										Z. MOR NUM	BER
Patrol Son	adron SIXT	EEN, US	SNAS	, Jacks	onvill	e 12,	Flor	ida		6-62	
(0)	inre c	MC USN	14	Aug 62	(b) (6	DED (Name)	and Signa	CDR	USN	15 A.	g 62
ACCIDENT	ACCIDENT	INCIDENT	10	44 EST		ul 62	8. GEOG	ni. west	ON NAS	Glync	o, G
P2V-5FS	131441	6	CUPANTS	B=2		A CODE	14. UNI	trol Squa			
NAME (Last, first	and middle initials)	UNI		G. CH ATTACHED	17. RANK, RATE	FILE/SE	1.	19,	BRANCH OF	21. INJURY	ZZ. DISPO.
McHugh, P		VP.	-16		LT	(b) (6)		PPC	USN	A	SITION
Broughton,	James A.	VP.	-16		LT			Student Pilot	USN	A	Y
inderson,	Ronald W.	VP.	-16		ADR3			Plane Captain	USN	A	Y
awthon, Ja	ames V.	VP.	-16	A	TCA			Radio Operato	usn	A	Y
		CESSAKI									
4. MODEL - OTHER A/	C IF INVOLVED	25. BUNO	26. 8	NO. OF OCCUPANT	5 27. UI	NIT OPERATIO	NG A/C	28.	DAMAGE COD	29. REP	ORT NO.

ADR3

#30. See The Accident.

f. Willis, Harry C. VP-16

_			SECTION B - MEDICAL OF	FICER'S QUESTIONNAIRE			
YES	NO	DID THE FLIGHT SURGEON:	(If "NO" state reason in space below.)				
ĸ		1. VISIT THE SCENE OF THE MISHAP?					
		2. PARTICIPATE FULLY IN THE FIELD INVESTIGATION?					
ζ.		3. PARTICIPATE FULLY IN THE DELIBERATIONS OF THE A/C ACCIDENT BOARD?					
GIVE APPROXIMATE NUMBER OF HOURS SPENT BY THE FLIGHT SURGEON:		GHT SURGEON:	4. IN FIELD INVESTIGATION	5. IN BOARD DELIBERATIONS	6. IN PREPARATION OF THIS REPORT		
V .	LL PA	REPARATION CHECK LIST RTS OF SURVIVORS COMPLETED X NARRATIVES	X PHOTOS X	CONCLUSIONS AND	EQUIRED COPIES		

Second

Mech.

USN

PART V THE ACCIDENT

On 23 July 1962 P2V-5F BUNO 131441 received take off instructions from the control tower, NAS Jacksonville, Florida, and took off at 0835 EST with a crew of six on board. The aircraft had a fuel load of 2300 gallons, with a gross weight of 68,676 pounds. The flight was scheduled as a 6.0 hour local flight on Patrol Squadron SIXTEEN (VP-16) flight schedule for 23 July 1962. The mission as scheduled was to be Instrument 7 (GCA) from the COMFAIRWINGSLANT flight training syllabus. A concurrent mission was to have been an operational and functional check of equipment and systems prior to transfer for induction into the PAR program on 8 August 1962. This was to be done throughout the entire flight and no specific time assigned for this purpose. A pre-transfer flight test sheet was issued to the pilots by the Squadron Quality Control

After approximately one hour and fifteen minutes of flight the aircraft commenced practice GCA approaches to low passes, in VFR conditions, Officer prior to taxi. to runway 25 at NAS Glynco, Brunswick, Georgia. The first three practice approaches were normal in all respects. The fourth approach was a no gyro approach to GCA minimums (100 feet and one quarter mile), and low pass. After the aircraft executed a wave off from this approach witnesses in the vicinity of the airfield observed smoke trailing from the starboard reciprocating engine. The aircraft proceeded down runway 25 at approximately 250 feet of altitude in level flight. Shortly after the aircraft passed the upwind end of the runway a control tower operator, using binoculars, observed the port propeller to go into full feather and stop. The port wing dipped momentarily. The aircraft then proceeded straight ahead, wings level, in a shallow glide and disappeared into the trees. Immedi-

ately thereafter a large ball of fire was observed. The crash occurred at 1044 EST after two hours and nine minutes of flight at approximately two miles beyond the upwind end of runway 25. The estimated aircraft weight at this time was 64,746 pounds. The crash circuit at NAS GLYNCO was energized at 1044 EST by control tower. personnel. A rescue helicopter arrived over the crash scene approximately ten minutes later. An MB-1, fire fighting truck, arrived about twenty minutes after the crash, having proceeded through a heavy growth of pine trees, brush, and palmeto, seemingly impenetrable by ground vehicle. At the time that rescue personnel and equipment arrived, the aircraft was engulfed in heavy flames, with no apparent indication of survivors. Rapidly spreading fire through the underbrush hampered attempted rescue operations; however, the MB-1 was able to discharge its full supply of foam over portions of the burning wreckage. The aircraft wreckage was positively identified as EUNO 131141 by the numbers on the vertical stabiliżer.

MEDICAL OFFICER'S REPOR DF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT-Page 2

OPNAV FORM 3750-8A (REV. 5-58)

OPNAV REPORT 3750-7

SECTION C-PHYSIOLOGICAL HUMAN AGMEERING, DESIGN, SOCIO-PSYCHOLOGICAL A. INING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

NAME OF INDIVIDUAL (Last, first, middle)

MODEL A/C

McHUGH, Philip R.

6. Total flight time

P2V-5FS

Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.). Attach all sheets pertaining to these factors to this form upon completion.

S	P	√ FACTORS	E	S	P	√ FACTORS
		PHYSIOLOGICAL:				SOCIO-PSYCHOLOGICAL (Emotional stress from duty sources
		1. Physically incapacitated in flight				29. Expeditings/Delays
		2. "G" forces				30. Weather
		3. Environmental stress - External	X			31. Mechanical Problems
		4 Internal				32. Social and working relationships
		5. Dysbarism/explosive decompression				33. Personal comfort
-		6. Diet				34. Regulations
10		7. Fatigue		1		35. Facilities
		8. Нурохіа				36. Navigation
		9. Related illness				37. Duty assignment
		10. Vertigo/Disorientation/Illusions				38. Personality traits
		11. Hyperventilation				NON-STRESS FACTORS:
		12. Drugs				39. Faulty attention
		13. Physical state				40. Poor judgement
		14. OTHER				41. Forgetfülness
		HUMAN ENGINEERING AND DESIGN:				42. OTHER SOCIO-PSYCHOLOGICAL FACTORS
4		15. Personal equipment				
X		16. Displays and/or controls				
		17. Work arrangement				
		18. Working environment				
		19. Habit interference				TRAINING FACTORS:
		20. OTHER:				43. Physiological training
		SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources)				44. Emergency Procedures training
		21. Pregnancy 22. Illness or death 23. Arguments				45. Survival and rescue training
						46. Refresher training
						47. Transition training
98		24. Elated/Depressed state				48. OTHER:
		25. Personal habits - Drinking				
		26 Sex				
		27 Gambling 28 Debts				
		SECTION D - AIR CREW	DAT	A	(fill	in where applicable)
Flis	ght t		-	10000	_	time in model 1117.2
Flig	ght t	House Control of the	8	. N	ımb	per of days grounded last month, give reason
Nu	mber			W.E		None
Tin	ne a	t controls this flight Unknown	9	. N	umb	per of and dates of previous accidents
5. Number of hours duty last 24 hours 3						
	X Fili Fili Nu	X Flight to Number Time a	PHYSIOLOGICAL: 1. Physically incapacitated in flight 2. "G" forces 3. Environmental stress - External 4 Internal 5. Dysbarism/explosive decompression 6. Diet 7. Fatigue 8. Hypoxia 9. Related illness 10. Vertigo/Disorientation/Illusions 11. Hyperventilation 12. Drugs 13. Physical state 14. OTHER: HUMAN ENGINEERING AND DESIGN: 15. Personal equipment X 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex 27 Gambling 28 Debts SECTION D - AIR CREW Flight time past 30 days Flight time last 24 hours 1 Unknown	PHYSIOLOGICAL: 1. Physically incapacitated in flight 2. "G" forces 3. Environmental stress - External 4 Internal 5. Dysbarism/explosive decompression 6. Diet 7. Fatigue 8. Hypoxia 9. Related illness 10. Vertigo/Disorientation/Illusions 11. Hyperventilation 12. Drugs 13. Physical state 14. OTHER! HUMAN ENGINEERING AND DESIGN: 15. Personal equipment X 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference 20. OTHER! SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex 27 Gambling 28 Debts SECTION D - AIR CREW DAT Flight time past 30 days Flight time past 30 days Flight time last 24 hours Number of flights in last 24 hours Time at controls this flight Unknown	PHYSIOLOGICAL: 1. Physically incapacitated in flight 2. "G" forces 3. Environmental stress - External 4 Internal 5. Dysbarism/explosive decompression 6. Diet 7. Fatigue 8. Hypoxia 9. Related illness 10. Vertigo/Disorientation/fliusions 11. Hyperventilation 12. Drugs 13. Physical state 14. OTHER: HUMAN ENGINEERING AND DESIGN: 15. Personal equipment 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex 27 Gambling 28 Debts SECTION D - AIR CREW DATA Flight time past 30 days Flight time past 30 days Flight time last 24 hours Number of flights in last 24 hours Time at controls this flight Unknown 9. No	PHYSIOLOGICAL: 1. Physically incapacitated in flight 2. "G" forces 3. Environmental stress - External 4 Internal 5. Dysbarism/explosive decompression 6. Diet 7. Fatigue 8. Hypoxia 9. Related illness 10. Vertigo/Disorientation/Illusions 11. Hyperventilation 12. Drugs 13. Physical state 14. OTHER: HUMAN ENGINEERING AND DESIGN: 15. Personal equipment X 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex 27 Gambling 28 Debts SECTION D — AIR CREW DATA (full Flight time past 30 days Flight time last 24 hours Number of flights in last 24 hours Time at controls this flight Unknown 9. Numb

1612.3 SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSIS (As condensed from Part I, Sect. D and Part VIII of the ARR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A. i.e. 15(a). Attach additional sheets as necessary.

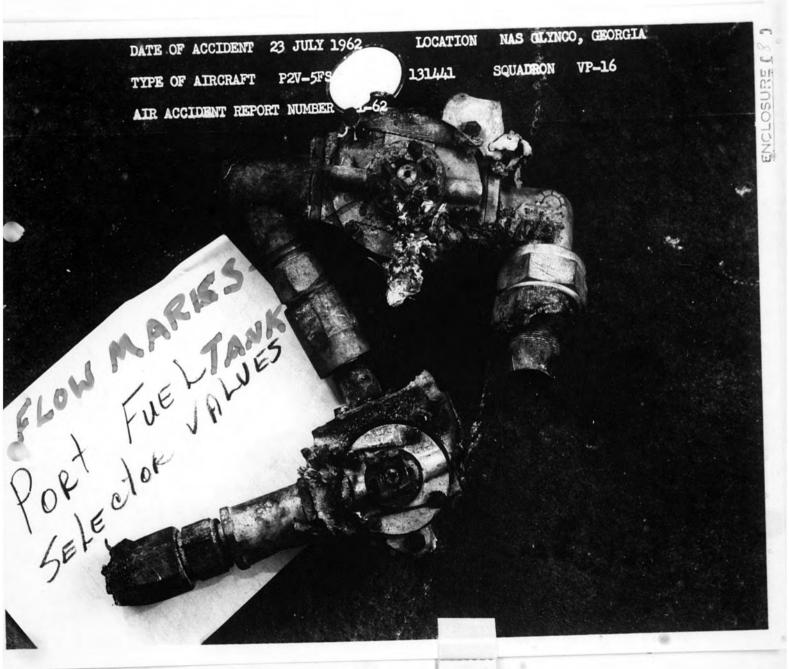
See Part VIII, AAR, "The Analysis."

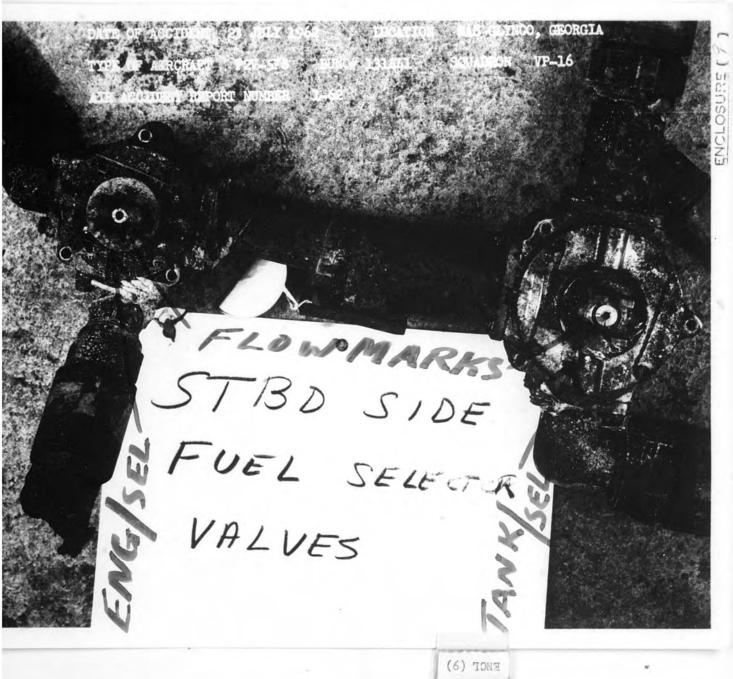
None

(Continued on OPNAY FORM 3750-8C)

SECTION F - SAFETY, PERSONAL, AND SURVIVAL EQU. Prepare a narrative account of damaged or failed items. Identify each item discussed (e.g., F1, F2, etc.) NAME OF INDIVIDUAL (Last, first, middle) McHUGH, Philip R. P2V-5FS AVAIL-GENERAL DESCRIPTION OF UTILIZED FAILED DESCRIPTION OF DAMAGE YES NO YES NO YES NO 1. Shoulder harness Type H Not found 2. Lap belt NAF 1201-8B X X Not found 3. Inertia reel 0-4600-103 X X Not found 4. G-Suit 5. Pressure suit-full or partial 6. Exposure suit 7. Flight suit (Other than above) Summer Flying x X Burned 8. Helmet DH 51-4 7. Not found 9. Goggles/Eyeshield X 10. Shoes Flying Boots X Burned X 11. Gloves Standard Issue Not found 12. Life vest Mae West X Not found 13. Life raft MK VII (2) X Not found 14. OTHER: 15. SIGNAL DEVICE - Flare (Night) MK XIII X Not found мк хш - Flare (Day) X Not found - Dve marker MK XIII X Not found - Radio AN/GRT-3 X Not found 19. - Flashlight Vest Light X Not found 20. - Mirror 21. OTHER: 22. SURVIVAL GEAR - Knife Standard Issue Not found X 23. - First ald kit PSK-11 X Not found - Shelter - Food 26. OTHER: 27. RESCUE - Vehicle - Sling, Net, Stretcher 29. OTHER: SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE 1. MASK - MODEL OR TYPE 2. MODIFICATIONS, IF ANY A-13A None 3. REGULATOR - MODEL OR TYPE 4. MODIFICATIONS, IF ANY 2872 None 5. PREFLIGHTED BY USER? 7. LIST DISCREPANCIES NOTED BY PREFLIGHT CHECK YES X NO Not usual routine in P2V TIME OF ACCIDENT B. OXYGEN SUPPLY: 9. WAS OXYGEN IN USE AT TIME OF _ LITERS (Liquid) 1600 P.S.I. (Gas) _ LITERS (Liquid) 1600P.S.I. (Gas) YES X NO 10. IF YES, WAS SELECTOR SETTING 11. WAS ALL OXYGEN EQUIPMENT NECESSARY FOR THIS FLIGHT AVAILABLE? IF NO, LIST ITEMS AND REASON WHY. YES NORMAL 12. WAS DAYGEN MASK REMOVED AT ANY TIME IN FLIGHT? IF YES, GIVE DURATION AND REASON. NO YES 13. TYPE CHUTE RELEASE DEVICE 14. TYPE HARNESS RELEASE DEVICE 15. WHEN WERE RELEASE DEVICES ACTIVATED! 16. WERE DIFFICULTIES ENCOUNTERED WITH RELEASE DEVICES! IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. YES NO 17. WERE DIFFICULTIES ENCOUNTERED AFTER ACTIVATING RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. YES NO 18. WAS LIFE YEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES? IF YES, WHAT DIFFICULTIES DID THIS PRODUCE? YES

TO U. S. GOVERNMENT PRINTING OFFICE : 1960-54:





Oil & HyD Shut OFF VALVE STED ENG DATE OF ACCIDENT 23 JULY 1962 IDCATION NAS GLYNCO, GEORGIA TYPE OF AIRCRAFT. P2V-5FS BUNO# 131441 SQUADRON AIR ACCIDENT REPORT NUMBER

PORT ENGINE
PORT PROP

FULL FEATHER

DATE OF ACCIDENT 23 JULY 1962 LOCATION NAS GLYNCO, GEORGIA

TYPE OF AIRCRAFT. P2V-5FS BUNO# 131441 SQUADRON VP-16

AIR ACCIDENT REPORT NUMBER 1-62

ENGT (II)

STBD ENG PROP DOME LOWPITCH STOP

DATE OF ACCIDENT 23 JULY 104

LOCATION NAS GLYNCO, GEORGIA

TYPE OF AIRCRAFT

BUNO# 131441

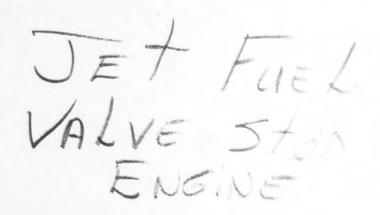
SQUADRON VP-16

AIR ACCIDENT REPORT NUMBER 1-62

DATE OF ACCIDENT 23 JULY 1962 LOCATION NAS GLYNCO, GEORGIA TYPE OF AIRCRAFT P2V-5FS BUNO# 131441 SQUADRON VP-16 AIR ACCIDENT REPORT NUMBER 1-62 10 M 5+BD JET throther Actumber

ploon. AS GLYNCO, GEORGIA ADRON VP-16

ENCT (TT)





DATE OF ACCIDENT

TYPE OF AIRCRAFT P2V-5FS

LOCATION

BUNO# 131441

NAS GLYNCO, GEORGIA

VP-16

SQUADRON

AIR ACCIDENT REPORT NUMBER

1-62





DIAGRAM OF INCIDENT SHOWING WIND, DIRECTION, APPROACH OF EQUIPMENT, POSITION OF AIRCRAFT, DISTANCES, ETC. (Haps and photographs should be included, if significant)

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FULL DESCRIPTION OF FIREFIGHTING OR PROTECTION AT INCIDENT

1044 1044:30 1044:30	Time of crash. Dispatched helicopter with crash rescuemen and doctor aboard.
1046	Dispatched 1 MBS Tractor, 1 MB-1. Dispatched 1 MB-5, 2 MB-2 (Dry chemical unit aboard).
(All times	approximate)
1045	Helicopter arrived at scene.
1055	MB-1 arrived at aircraft, discharged from and had dies at any
1100-1130	Back up crash fire crews arrived, extra assistance, Georgia Forestry Service, NAS structural firefighting equipment (1 unit, bulldozer
1105	Grash fire Officer, crash fire PO, doctor arrived.
1130	50-hand fire fighting party, NAS Security Officer and firefighting equipment arrived (co, shovels, brush beaters, water tanks)
1200	Brunswick Pulp and Paper Corp. equipment, bulldoser and Forestry Service bulldoser, NAS bulldoser, and one piece of private equipment provided firebreak and fire control assistance.
1200-1600	Mop up crews, 50-100 hand parties.

F INDIVIDUAL (Last	t, first, siddle)	ON G - DETAILED EQU		The low		MODEL A/C
	Philip R.					P2V-5FS
. INTEGRATED HARM	NESS SYSTEM, MODEL/TYPE	20. INTEGRATED?		ICATIONS. IF A	NY STATE REAS	ON .
DID INTERNATION	HADDECE FIT BRADERIVE IS	F NO. LIST DISCREPANCIES IN	FIT AND GIVE REASO	NS THEREFOR		
NO TY		no, Eler Viscour Moles In	7116			
	NESS FITTING WAS CONDUCTE	ED BY:				
WEARER	FLIGHT SURGEON	PARACHUTE RIGGER	AVIATION EQU	IPMENT OFFICER		ЭТНЕВ
	ENESS WAS USED, WAS IT		7			
LOCKED L	UNLOCKED TIG	CRIBED MODIFICATIONS	OTHER CONDITION			
DH51-4	None	CHIDED MODIFICATIONS				
COLUMN TO STATE OF THE PARTY OF	TIONS AND REASON FOR THEM		28. DID HELMET	FIT PROPERLY?	IF NO. GIVE R	EASON
			X YES	NO		
HELMET FITTING		V		IDUENT AFFICE		OTHER
X WEARER	FLIGHT SURGEON	X PARACHUTE RIGGER	BAILOUT OXYGEN	133. AUTOMAT		F INSTALLED (Hodel and type)
N3CR	7-12-62		DALEGOT ONTOCK	NONE		, ,
	RIPCORD FAILT IF YES, WHY				35. WAS RIPC	ORD ACTIVATION
NO					MANU	AL AUTOMATICS
8. IF MANUALLY ACT	TIVATED STATE REASON AND	MY DIFFICULTIES ENCOUNTER	RED			
7 DID CHITE ARD	IMMEDIATELY? IF NO. GIVE	E DEACON			- 13	8. ALTITUDE THAT CHUTE OPENED
YES N						FEE
. OPENING SHOCK	WASI	40. BODY ATTITUD	AT OPENING	41. CONDITION	OF CHUTE AFT	ER OPENING
SLIGHT	MODERATE SET	VERE				
2. CHUTE OSCILLAT	ION PRESENT:	43				
		Sc. 19 (2.7.6)	. IF OSCILLATION WAS	PRESENT. HOW	WAS IT STOPPE	DI
NONE	SLIGHT MODERA					DI .
	SLIGHTMODERA			FRESENT. HOW		
	IONS DURING DESCENT (Lie	t in sequence)		Y OF LANDING S		DT .
4. WEATHER CONDIT	IONS DURING DESCENT (Lie	t in sequence) 47. WAS	45. TOPOGRAPH BAILOUT OXYGEN USEC	TY OF LANDING S	HTE	
4. WEATHER CONDITION 6. WAS BAILOUT OX BEFORE EXIT 8. WHEN WAS IT AC	IONS DURING DESCENT (Lie	t in sequence) 47. WAS	45. TOPOGRAPH	TY OF LANDING S	HTE	
4. WEATHER CONDITION 6. WAS BAILOUT OX BEFORE EXIT 8. WHEN WAS IT AC BEFORE EXIT	IONS DURING DESCENT (Lie YGEN CONNECTED? AFTER EXIT AFTER EXIT	NO N.A. Y	45. TOPOGRAPH BAILOUT OXYGEN USES NO IES ENCOUNTERED WITH	OF LANDING S OF IF NOT, WHY	ITE	AUSE, IF MY
4. WEATHER CONDITION 6. WAS BAILOUT OX BEFORE EXIT 8. WHEN WAS IT AC	IONS DURING DESCENT (Lie YGEN CONNECTED? AFTER EXIT AFTER EXIT	NO N.A. Y 47. WAS NO N.A. Y 49. GIVE DIFFICULY	BAILOUT OXYGEN USED BAILOUT O	OF LANDING S	ITE	AUSE, IF MY
4. WEATHER CONDITION B. WAS BAILOUT OX BEFORE EXIT B. WHEN WAS IT AC BEFORE EXIT O. WAS CHUTE HARNI TIGHT	IONS DURING DESCENT (Lie	t in sequence) A7. WAS NO N.A. Y 49. GIVE DIFFICULY 51. WAS A SITTING NO Y	BAILOUT OXYGEN USED ES NO IES ENCOUNTERED WITH	TY OF LANDING S OF IF NOT, WHY R BAILOUT OXYGE	ITE IN AND THEIR C	AUSE, IF ANY
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SE ON H.	CCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 5
NAME OF INDIVIDUAL (Last, first, middle)	EMERGENCY EXIT FROM A/C AND SURVIVA. ACTORS
McHUGH, Philip R.	MODEL A/C
S E S.SUSPECTED, E-ESTABLISHED	P2V-5FS
1. EJECTION - Attempted	REMARKS
2 Accomplished	
3 Through canopy	
YES NO EJECTION DIFFICULTIES ENCOUNTERED	IF YES, EXPLAIN DIFFICULTIES
4 Prior to	The same surriculties
5 During	
6 Subsequent to	
 Give type and model of seat used 	
8. BAILOUT - Attempted	
- Accomplished	
ALTITUDE AT TIME OF EXIT (feet)	10. ATTITUDE OR MANEUVER OF A/C AT EXIT OR IMPACT
BOVE SEA LEVEL ABOVE TOPOGRAPHY 2. COLLISION OF A/C WITH 13. CONTROLLED	
V	Wings level, slight nose high 90-110 kno
T. CANOPY POSITION AT EXIT OR IMPACT 18. SEA ST	UNKNOWN X ON SOFF VIE COME CONTRACTOR
	TATE IN THE PARTIE
JETTISONED JETTISONED	88 °F SEC. 20. WATER TEMP. 21. A/C FLOATED 22. TIME IN WATER 23. TIME IN RAF
OR NORS 25. IS THIS THE R	ECOMMENDED EXIT! IF NO STATE REASON FOR CHOICE.
None YES	NO
SION IN IN IN IN	27. STATE NATURE OF DIFFICULTY
WATER REACHING OPENING EXITIN	NG
OR 28. BODY POSITION DURING EXIT	
	ground.
RVIVAL FACTORS: Check factors below which	
RVIVAL FACTORS: Check factors below which are factors checked below and attached the factors of	
IRVIVAL FACTORS: Check factors below which are factors checked below and attachment of the factors of the facto	appropriate for this accident. Prepare a detailed narrative account of the ch to this form. Identify each item discussed by item number (e.g., H30,
MMUNICATIONS:	
30. Communicated position prior to mishap	appropriate for this accident. Prepare a detailed narrative account of the ch to this form. Identify each item discussed by item number (e.g., H30,
30. Communicated position prior to mishap 31. Witnesses at scene	appropriate for this accident. Prepare a detailed narrative account of the ch to this form. Identify each item discussed by item number (e.g., H30,
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1. NAME OF	INDIVI	DUAL (L	ast,	first,	GICA	PACTO	KS (Use	A to	denote	ANTE N	ORTEM;	P fo	rh	MORT	EM, wh	en kr	iown a				.)
McHU																			EL N	T. 1	
2. AGE	3. HE	GHT		4. WE					TION FAC		TIME OF	ACCIDE	NT	-		_	_	P	- V -	5F	S ULNI.
30 7. UNCONSC	72	INC	HES	17	8				t Sea	at										1°	A
	ORT OUR			0	THER				e. INT	ERNAL IN	JURIES	(Non-f	atal .	cases)							-
		REBRAL			give tin	•)	-	-		O. FACI	AL IN III	DIEC /		,							
HEAD		MINOR		-	ious	CRIT	ICAL	X FAT	u		arri			,			NTRA-O				
INJURIES		NOR EYE	וענאו	RIES						T	13. MA	-	INJU	RIES		.viu	ltipl	e I	ra	ctuz	es
4.TYPE	_	RIGHT	-	_			LEFT				X	RIGHT					X u	PT			
OF FRACTURE	CRAN.	FACI		-	VERTEB		ectfy No.		SHOULDE	RIDS	PELVIS	UPPER	ARM	LOWER A	POM H	IAND	UPPER	LEO	LOWE	R LEG	FC
IMPLE	GRAT.	FACI	AL C	ERV.	HOR.	LUMBAR	SACRAL	COCCYX	GIRDLE	-	-	R	L	R	R	L	R	L	R	L	R
COMPOUND			-		-		-			-			_								
OMM INUTED									200	X	x	-	-	-	+	-	-				
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DIS-	***	9	_8	***	****	****	⋘	****	*****	₩	***	SHOUL	DER	ELBON	-	T	HI	P	KNE	EE	ANO
OCATION	***	x													H	AND					FO
- AMPUTATI	ONS/AVU		(State	e Pari	(4)		-	10 110	PRE-EXI												
HEAD	VENTRA	_	MILD	МО	DERATE	SEVERE			/SPRAIN	SEVE	_	LD		RATE	SEVERE	10	. 🗆	DROW	NED		
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a. e. ç.)	DORSAL	-		-	-	-	-	-			-							1			
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BURNS	-	DEUNEE	-			X		200		K	-	2010	-	X		NONE		_		E (a	1-
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TE: Att	ech a	latail	-4 -	X		X		X	X		X		X		SPECIA OBTAIN						NO
TE: Att	E- OR	OST-M	ORTEM	if	determi	ned. I	injuri t is ne	ies, ca	use, st	ructur	es cau	sing :	inju	ry, mag	nitude	s of	force	, and	inc	lude	whot
ADMITTED	TO SICK	LIST	IF YES	. GIV	E DIAGN	0515								S NO. (N	ary c	4480	una s	equen	ice a	s pos	mibl
X YES	NO	fc	rı	ec	ord	purp	ose o	only							THEO P	1254)	20.	IST	TED S	TAY ON	
GROUNDED!	X NO	GIVE R	EASON										7		-		28. 6	STIMA	TED D	URATIO	N C
		DEATH	(Use P	ant-	Diagram		1.						See at 1							DAY	
PRIMARY C	HIU	ILID	e.	ex	trem	e	No.	8651	P-1294)	30. SE	CONDARY	CAUSE	OF DE	ATH 1000	20						
AUTOPSY P	ERFORME	1		2. PR	OTOCOL				33. A	UTOPSY			*•	100%				NO		403	
X YES	NO			X	ATTACHED		WILL BE	E	X	PATHOL		_	LIGHT	GU	FLIGHT	A/C	ACC I DEN	T FAT	ALITIE	ES", A	FIP.
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101		-!								TISSUE	(CNS)				UNM		-		RESUL	18	2016
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IF ULTRAVI		Sept. 17.0				THE R. P. LEWIS CO., LANSING, MICH.			27 15				100	100000						_	

AUTOPSY: A-80-62

Name: McHUGH, Phillip Raymond Jr.

Race: Caucasian

Died: 7-23-62, 1044

Age: 29

Sex: Male

Autopsy: 9-23-62, 1000

CHINICAL SIMMARY: The person on whom this post-mortem examination is performed was the command pilot of a Navy P2V patrol bomber which crashed near NAS, Glynco, Georgia on 7-23-62. The plane was making practice landings in association with the GCA School at NAS, Glynco. The plane took a wave-off, began to accelerate, then apparently stalled and crashed approximately 4 miles from the landing strip. Indirect and hearsay information indicates that the plane acted as if a motor lost its power and precipitated a stall which caused the crash. The plane burned totally with all occupants inside the craft. Identification of these remains have been established by dental chart evaluations as well as by positions in the aircraft. Identification was carried out by the attending flight surgeon, Doctor Flack of NAS, Jacksonville and a dentist who is not known to this prosector.

EXTERNAL EXAMINATION:		
(b) (6)		

TOXICOLOGY:

(b) (6)

PHOTOGRAPHS: Photographs of this and other bodies involved in this plane crash were obtained by Fleet Air Photographic Laboratory, N.S., Jacksonville.

AUTOPSY: A-80-62 Name: McHUGH, Phillip Raymond Jr. GROSS FINDINGS:

INJURIES, MULTIPLE, EXTREME.

(b) (6) 2. 3.

CAUSE OF DEATH: Injuries, multiple, extreme (aircraft accident)

(b) (6)

MEDICAL OFFICER'S REPORT OF OPNAY FORM \$750-64 (Rev. 5-58)

4. Time at controls this flight

SECTION C - PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

HAME OF INDIVIDUAL (Last, first, middle) P2V-5FS BROUGHTON, James A.

BROUGHTON, James A.

Broblished, S-Suspected, or P-Present for each factor selected. Additional 8X10% plain sheets will be used for the supported by the factor and section identification (e.g., C1, C2, etc.)

ag acc	count of stems these factors to t	his form upon compl	6110	n.	litional 8X10% plain sheets will be used to and section identification (e.g.				
0.41	count of items checked below. Identify sheets pertaining to these factors to t	E	5	-	SOCIO-PSYCHOLOGICAL: (Exotional atro	ess from daty sources)			
P	PHYSIOLOGICAL:			-	29. Expeditings/Delays				
++	1. Physically incapacitated in flight		\sqcup		30. Weather				
+	2. "G" forces		Н		31. Mechanical Problems				
H	3. Environmental stress - External	X	-	-	32. Social and working relationshi	ips			
++	4 Internal		-	_	33. Personal comfort				
++	5. Dysbarism/explosive decompression		-	_	34. Regulations				
-	6. Diet		-	_	35. Facilities				
+	7. Fatigue		-	_	36. Navigation				
+	8. Hypoxia		-	-	37. Duty assignment				
-	9. Related illness		-	-	38. Personality traits				
-	10. Vertigo/Disorientation/Illusions		-	-	NON-STRESS FACTORS:				
-	11. Hyperventilation		-	-	39. Faulty attention				
-	12. Druge		+	+	40. Poor judgement				
-	13. Physical state		-	+	41 Forget fulness				
-	14. OTHER:		-	+	42. OTHER SOCIO-PSYCHOLOGIC	AL FACTORS			
-	HUMAN ENGINEERING AND DESIGN:		-	+	42. 0111211 0000				
	15. Personal equipment		-	+					
x	16. Displays and/or controls		-	+					
1	17. Work arrangement		-	+					
++	18. Working environment		-	+	TRAINING FACTORS: 43. Physiological training				
++	19. Habit interference		-	+					
+	20 OTHER:		-	+	44. Emergency Procedures training 45. Survival and rescue training				
++	SOCIO-PSYCHOLOGICAL: (Emotional stres	s from non-daty sources)	-	+					
++	21. Pregnancy			-	46. Refresher training				
1	22. Illness or death				47. Transition training				
++	23. Arguments				48, OTHER:				
1	24. Elated/Depressed state								
11	25. Personal habits - Drinking								
++	26 Sex		-						
++	27 Gambling		-	-					
++	28 Debts		1	_	ent de phone englicable)				
	SECTI		TAT	1 (fill in where applicable) Total time in model	418,6			
Plie	the time past 30 days	49.5	1		Sumber of days grounded last month, gr	ive reason			
F14.	the time last 24 hours	2.1	1		I I I I I I I I I I I I I I I I I I I	None			
	per of flights in last 24 hours		Unknown 9. Number of and dates of previous acc						

5. Number of hours duty last 24 hours 3058.6 SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSES (As condensed from Part I, Sect. D and Part VIII of the AAR) 6. Total flight time MOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach additional sheets as necessary.

0

See Part VIII, AAR, "The Analysis,"

None

MEDICAL OFFICER'S REPORT (OPNAV FORM 3750-8B (5-58)

A/C ACCIDENT. INCIDENT. OR GROUND ACCIDENT - PAGE 3 OPNAY REPORT 3750.7

			it of damaged or failed items.						MODEL A/C
BROUGHTON,	Jame	S .	Α.						P2V-5FS
EQUIPMENT OF	YES	AIL.	SPECIFIC MODEL OR TYPE	UT	ILIZE	D FA	ILED	DECCRION	
1. Shoulder harness		NO		YE	S NO	YES	NO	TO PO	ON OF DAMAGE
2. Lap belt	X	-	Type H	X	4	x		Burned	
3. Inertia reel	X		NAF 1201-8B	X		X			
4. G-Suit	X	_	0-4600-103	X		X		Fastened bu	ckle found
5. Pressure sult-full or partial		X				1		but remaind belt burned.	er of seat
5. Exposure suit		X						beit burned.	
7. Flight suit (Other than above)	v	X							
B. Helmet	X	_	Summer Flying	X				Burned	
. Goggles/Eyeshield	-	_	Helicopter	X		X		Earphones f	
. Shoes	X	_						remainder b	ound, the
. Gloves	X	_	Flying Boots	X		X		Burned	urnea.
. Life vest	X		Standard Issue	X		X		Not found	
	X		Mae West		X			Not found	
. Life raft (2)	X		MK VII		X			Not found	
OTHER:	++							Tound	
SIGNAL DEVICE - Flare (Night)	1	-							
- Flare (Day)	X		MK XIII		x		1	Not found	
- Dye marker	X	-	MK XIII		X		1	Not found	
- Radio	X		MK XIII		X		1	Not found	
- Flashlight	X	-	AN/GRT-3		X		1	Not found	
- Mirror	^	-	Vest Light		x		1	Not found	
OTHER:	++	-		,					
SURVIVAL GEAR - Knife	x	+	S4						
- First aid kit	X	+	Standard Issue PSK-11				I	Not found	
- Shelter	1	-	F3K-11				N	lot found	
- Food		+						V 414. (274-1915-191)	
OTHER:		+							
RESCUE - Vehicle		+		1					
- Sling, Net, Stretcher		+							
OTHER:		+							
		- 00	CTION C. DET.						
1. MASK - MODEL OR TYPE	2. MODI	FICAT	CTION G - DETAILED EQUIPME	NT QUI	STIC	NNA	RE		
A-13A		No							
3. REGULATOR - MODEL OR TYPE	4. MODI	FICAT	IONS, IF ANY						
2872		No							
5. PREFLIGHTED BY USER! 6. IF	NO. WHY					_			
YES X NO	Not u	su	al routine in P2V			7.	LIST DI	SCREPANCIES NOTED BY P	REFLIGHT CHECK
& OXYGEN I			TIME OF C		-				
SUPPLY: LITERS (14)	mid) 16	00			. 14			9. WAS OXYGEN	IN USE AT TIME OF
10. IF YES, WAS SELECTOR SETTING	11. WA	S ALL	OXYGEN EQUIPMENT NECESSARY FOR	THIS FILE	/	.00	.s.i. (Gas)	YES X NO
100% NORMAL		YES	NO			AILABL	Er if	NO, LIST ITEMS AND REAS	ON WHY.
12. WAS OXYGEN MASK REMOVED AT ANY	TIME IN	FLIGH	TT IF YES, GIVE DURATION AND REASO						
13. TYPE CHUTE RELEASE DEVICE	14. TYP	E HAI	NESS RELEASE DEVICE 15. V	HEN WE				S ACTIVATED?	
YES NO	ITH RE S	SE D	EVICES! IF YES, STATE DIFFICULTIES.	-	NCOU	TERES			
7. WERE DIFFICULTIES ENCOUNTERED AN	TER ACTI	MITAN	G RELEASE DEVICEST IF YES, STATE C	IFFICULT	IES, V	HEN E	NCOUP	TERED AND COMM	
. WAS LIFE VEST INFLATED PRIOR TO A								THE AND CAUSE.	
WAS LIFE WEST IN									

OP	PHAY FORM 8750-8C (5-58)	AGE 4 OPHAV REPORT 375
_	SECTION G - DETAILED EQUIPMENT QUESTIONNAL	
11.0		MODEL A/C
-	BROUGHTON, James A. 19. 'INTEGRATED HARNESS SYSTEM, MODEL/TYPE 20. INTEGRATED? 21. MODIFICATIONS	P2V-5FS
ES	20. INTEGRATED HARNESS FIT PROPERLY? IF NO. LIST DISCREPANCES IN FIT AND GIVE BEASONS THERE	The state readily
ARA	22. DID INTEGRATED HARNESS FIT PROPERLY? IF NO. LIST DISCREPANCIES IN FIT AND GIVE REASONS THERE	FOR
E		
RAIN	223. INTEGRATED HARNESS FITTING WAS CONDUCTED BY: WEARER FLIGHT SURGEON PARACHUTE RIGGER AVIATION EQUIPMENT OF	FFICER OTHER
EST	WEARER FLIGHT SURGEON PARACHUTE RIGGER AVIATION EQUIPMENT OF	
_	COCKED UNLOCKED TIGHT SLACK OTHER CONDITION	
	26. LIST PRESCRIBED MODIFICATIONS Helicopter	
MET		ERLYF IF NO. GIVE REASON
HELM	X YES NO	THE TO THE REASON
=	29. HELMET FITTING WAS CONDUCTED BY:	
	WEARER FLIGHT SURGEON X PARACHUTE RIGGER AVIATION EQUIPMENT O	FICER OTHER
		TOMATIC RIPCORD, IF INSTALLED (Wodel and type)
	N3CR 7-12-62 34. DID AUTOMATIC RIPCORD FAIL? IF YES, WHY?	NONE
	NO	35. WAS RIPCORD ACTIVATION
	36. IF MANUALLY ACTIVATED STATE REASON AND MY DIFFICULTIES ENCOUNTERED	MANUAL AUTOMATICE
	37. DID CHUTE OPEN IMMEDIATELY? IF NO. GIVE REASON	38. ALTITUDE THAT CHUTE OPENED
8	YES NO	FEET
		ITION OF CHUTE AFTER OPENING
	42. CHUTE OSCILLATION PRESENT:	
ш	The second was present	HOW WAS IT STOPPED?
PARACHUTE	44. WEATHER CONDITIONS DURING DESCENT (List in sequence) 45. TOPOGRAPHY OF LAND	ING CITY
RAC		110 0112
PA	48. WAS BAILOUT OXYGEN CONNECTED? 47. WAS BAILOUT OXYGEN USED? IF NOT.	WHY
	BEFORE EXIT AFTER EXIT NO N.A YES NO	
	48. WHEN WAS IT ACTIVATED? 49. GIVE DIFFICULTIES ENCOUNTERED WITH BAILOUT	OXYGEN AND THEIR CAUSE, IF ANY
	SO, WAS CHUTE HARNESS SI, WAS A SITTING POSITION IN SLING ORTANGE OF	
	50. WAS CHUTE HARNESS 51. WAS A SITTING POSITION IN SLING OBTAINED DO	RING DESCENT? IF NOT. WHY?
	52. SEAT CUSHION IF PROVIDED (Model/Type) 53. WAS PARARAT LANYARD CONNECTED TO LIFE VEST	D RING? IF NOT. WAY?
	NOME NO YES	
	84. LIST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL	
	NONE Lectures and demonstrations	
	SS. IF ATTEMPT WAS MADE TO RELEASE PARARAFT DURING DESCENT, WAS S4. IF NO. GIVE REASON RELEASE ACTIVATED SUCCESSFULLY!	
	TT. IF G-SHIT EVENSING SHIT SHIT OR SAPTIM PROCESSING SHIT SHIT	
	57. IF G-SUIT, EXPOSURE SUIT, FULL OR PARTIAL PRESSURE SUIT WAS WORN, DID IT FIT PROPERLY! IF NOT THEREFOR.	LIST DISCREPANCIES IN FIT AND GIVE REASONS
	TES NO	
ı	58. WAS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF NO. GIVE REASON	
	YES NO	
OTHER	80. LIST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED	
5		
	60. WAS MY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM, WHEN LOST, AND 61. WAS MY ITEM OF EQUIPMENT LOSS. AND REASON FOR DISCAR	ENT DISCARDED? IF YES, STATE ITEM, WHEN DISCARDED.
1	NO YES	
200		

	INDIVIDUAL (Last, first, middle)	EMERGENCY EXIT FROM A/C AND SURVIVA. ACTORS
		MODEL A/C
S E		P2V-5FS
-	TOTAL ESTABLISHED	REMARKS
	1. EJECTION - Attempted 2 Accomplished	
	riccompilation	
YES NO	3 Through canopy	
TES NO	DIFFICULTIES ENCOUNTERED	IF YES, EXPLAIN DIFFICULTIES
-	4 Prior to	
-	5 During	
******	6 Subsequent to	
···	7. Give type and model of seat used	
-	8. BAILOUT - Attempted	
	- Accomplished	
	E AT TIME OF EXIT (feet)	10. ATTITUDE OR MANEUVER OF A/C AT EXIT OR IMPACT
BOVE SEA	ABOVE TOPOGRAPHY	Wings level slight
		14. POWER 15. WHEELS 16. FLAPS
	POSITION AT EXIT OR IMPACT IN SEA ST	UNKNOWN X ON SORE W.
POPE		ATE 19. AIR TEMP. 20. WATER TEMP 21 AGE TOWN
	THE THE PETTISONED	88 °F
AIL OUT	24. EXIT USED 25. IS THIS THE RE	ECOMMENDED EXIT! IF NO STATE REASON FOR CHOICE.
OR COLLI.	TAOME ALE	NO
SION	26. DIFFICULTIES WITH THIS EXIT WERE	27. STATE NATURE OF DIFFICULTY
WITH	IN IN	
WATER	28. BODY POSITION DURING EXIT	G
ROUND		
RVIVAL F		
	ACTORS: Check factors below which are	Springels for the
	ACTORS: Check factors below which are factors checked below and attac H31, etc.)	appropriate for this accident. Prepare a detailed narrative account of the h to this form. Identify each item discussed by item number (e.g., H30)
_		appropriate for this accident. Prepare a detailed narrative account of the to this form. Identify each item discussed by item number (e.g., H30,
30. C	Communicated position prior to mishap	MAINTAINING BODY TEMPERATURE:
30, C	Communicated position prior to mishap Witnesses at scene	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter
30, C 31, V 32, E	Communicated position prior to mishap Witnesses at scene Electronic signal devices	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing
30. C 31. V 32. E 33. V	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire
30. C 31. V 32. E 33. V	Communicated position prior to mishap Witnesses at scene Electronic signal devices	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER:
30. C 31. V 32. E 33. V 34. A	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS:
30. C 31. V 32. E 33. V 34. A	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices auditory signal devices	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces
30. C 31. V 32. E 33. V 34. A 35. O	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER:	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants
30. C 31. V 32. E 33. V 34. A 35. O /EL:	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER:	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants
30. C 31. V 32. E 33. V 34. A 35. O /EL:	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices WITHER:	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces
30. C 31. V 32. E 33. V 34. A 35. O 7/EL: 36. L 37. W	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices WITHER:	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population
30, C 31, V 32, E 33, V 34, A 35, O (EL: 36, L 37, W TER: 38, Li	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER: AND VATER	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER:
30, C 31, V 32, E 33, V 34, A 35, O /EL: 36, L 37, W TER: 38, Li 39, Pa	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER: AND VATER life raft arachute	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE:
30. C 31. V 32. E 33. V 34. A 35. O (EL: 36. LL 37. W.TER: 38. Li 39. Pa 40. A 40. A 40.	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER: AND VATER life raft arachute //C structure	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock
30. C 31. V 32. E 33. V 34. A 35. O (EL: 36. L 37. W TER: 38. Li 39. Pe 40. A 41. Ne	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Unditory signal devices WHER: AND WATER Ife raft arachute //C structure atural shelter	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation
30. C 31. V 32. E 33. V 34. A 35. O 7EL: 36. L 37. W TER: 38. Li 39. Pe 40. A 41. Ne 42. Ma	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER: AND VATER life raft arachute //C structure atural shelter an-made shelter	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom
30. C 31. V 32. E 33. V 34. A 35. O 7EL: 36. L 37. W TER: 38. Li 39. P2 40. A 41. Ne 42. Ma 43. O 7	Communicated position prior to mishap Witnesses at scene Electronic signal devices Visual signal devices Auditory signal devices VIHER: AND VATER Ife raft arachute //C structure atural shelter an-made shelter FHER:	MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom 62. Rationing, activities, and group coordination
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CONTENTS		1			-			11 01	THERE									_	_	

AUTOPSY: A-84-62 Name: BROUGHTON, James Albert Race: Caucasian Age: Died: 7-23-64, 1044 Sex: Male Autopsy: 7-25-62, 1000 CLINICAL SUMMARY: This officer was part of a crew of a Navy P2V patrol bomber, which crashed on 7-23-62. (See 1st para. of Autopsy 80-62 for details of this crash). The exact status of this officer in the crew has not been available to prosector. EXTERNAL EXAMINATION: SUMMARY OF GROSS FINDINGS: GROSS PATHOLOGIC DIAGNOSES: Injuries, Multiple, Extreme. 2. 3. CAUSE OF DEATH: Injuries, multiple, extreme (Aircraft accident). LCDR MC USN

SECTION C - PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

HAME OF INDIVIDUAL (Lest, first, middle) ANDERSON, Ronald W.

Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8X10% plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., Cl, C2, etc.). ESP ESP ✓ FACTORS J FACTORS PHYSIOLOGICAL: SOCIO-PSYCHOLOGICAL: (Enotional stress from daty sources) 1. Physically incapacitated in flight 29. Expeditings/Delays 2. "G" forces 30. Weather 3. Environmental atress - External 31. Mechanical Problems 32. Social and working relationships 5. Dysbarism/explosive decompression 33. Personal comfort 6. Diet 34. Regulations 7. Fatigue 35. Facilities 8. Hypoxia 36. Navigation 9. Related illness 37. Duty assignment 10. Vertigo/Disorientation/Illusions 38. Personality traits 11. Hyperventilation NON-STRESS FACTORS: 12. Drugs 39. Faulty attention 13. Physical state 40. Poor judgement 14. OTHER: 41. Forgetfulness HUMAN ENGINEERING AND DESIGN: 42. OTHER SOCIO-PSYCHOLOGICAL FACTORS 15. Personal equipment 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference TRAINING FACTORS: 43. Physiological training SOC 10 - PSYCHOLOG I CAL : (Emotional stress from mon-daty sources) 44. Emergency Procedures training 21. Pregnancy 45. Survival and rescue training 22. Illness or death 46. Refresher training 23. Arguments 47. Transition training 24. Elated/Depressed state 48. OTHER: 25. Personal habits - Drinking 26. 27. - Gambling 28. - Debts SECTION D - AIR CREW DATA (fill in where applicable) 32.7 7. Total time in model 519.9 2.1

1. Flight time past 30 days
2. Flight time last 24 hours
3. Number of flights in last 24 hours
4. Time at controls this flight
5. Number of hours duty last 24 hours
3. Sumber of hours duty last 24 hours
4. Time at controls this flight
5. Number of hours duty last 24 hours
6. Total flight time
5. Number of hours duty last 24 hours
5. Number of hours duty last 24 hours
6. Total flight time
5. Number of hours duty last 24 hours
5. Number of hours duty last 24 hours
5. Number of hours duty last 24 hours
6. Total flight time
5. Number of hours duty last 24 hours
5. Number of hours duty last 24 hours
5. Number of hours duty last 24 hours
6. Total flight time

SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSES (As condensed from Part I, Sect. D and Part VIII of the AAR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach

additional sheets as necessary.

See Part VIII, AAR, "The Analysis."

	Trong	rid	CTION F - SAFETY, Pount of damaged or fo							MODEL A/C
GENERAL DESCRIPTION OF	F	ABLE		IFIC	1171	LIZED	1			P2V-5FS
1. Shoulder harness		24		R TYPE	YES	_	YES	ILED	DESCRIPT	ON OF DAMAGE
2. Lap belt		x 2			- 1	X	100	NO		ON OF DAMAGE
3. Inertia reel		X	NAF 1201-	8B		X	-	-	Not found	
4. G-Sult	1	X				X			Not found	
5. Pressure suit-full or partial		X				-			Not found	
6. Exposure suit		x								
7. Flight suit (Other than above,	2									
8. Helmet	X		Summer F	lying	K		x		Burned	
9. Goggles/Eyeshield 10. Shoes	X				1			1	Not found	
11. Gloves	X		Field Shoes		1			1	not found	
12. Life vest	X		Standard Is	Suo X	4	2	2	I	Burned	
2 716	X		Mae West		-	-		N	Not found	
4. OTHER:	X		MK VII		12		1	N	Not found	
	-				2	-		N	ot found	
5. SIGNAL DEVICE - Flare (Night)	-	-			+	-	-			
5 Flare (Day)	X	-	MK XIII		x	+	-	-		
. Dye marker	X		MK XIII		x		+	N	ot found	
Radio	X	1	MK XIII		x		+	_N	ot found	
- Flashlight	X		AN/GRT-3		X	1	+	-IN	ot found	
- Mirror	X		Vest Light		X		+	TING	ot found	
OTHER:		-						TING	ot found	
SURVIVAL GEAR - Knife	X	S	tandard Issu					1		
- First aid kit	X	P	SK-11		X			Bu	rned	
- Shelter					X			No	t found	
- Food	1]	Lound	
RESCUE - Vehicle	++							1		
- Sling, Net, Stretcher	++	-			-					
OTHER:	++	-			-					
			100		-	-				
1. MASK - MODEL OR TYPE	2. NO	SEC	TION G - DETAILED E	EQUIPMENT OU	CCT					
A-13A		cario			2311	ONNA	AIRE			
3. REGULATOR - MODEL OR TYPE	4. MOI	IFICATIO	None							
2872 5. PREFLIGHTED BY USER? 6. 11	194		None			-	-	-		
TES TES	NO. WHI	NOT	MARKET IN THE SECOND STREET							
No.	ot us	ual	routine in I	221/		7.	LIST	DISCRE	EPANCIES NOTED BY PREF	I IONE COL
8. OXYGEN PRIOR TO FLIGHT			, TIME OF	ACCIDENT						CHECK
O. IF YES, WAS SELECTOR SETTING	uid) 16	000	S.I. (Gas)	- LITERS (1)-			200		9. WAS OXYGEN IN U	SE AT TIME
100% NORMAL	II. WA	S ALL OF	NO NO	ARY FOR THIS FUE	16	000	P.S.1.	(Gas)	ACCOT. TYES	X NO
R. WAS OXYGEN MASK REMOVED AT ANY		LES L		100		AILABI	LE? II	F NO. 1	LIST ITEMS AND REASON Y	VHY.
NO YES	IN	LIGHT	IF YES, GIVE DURATION A	ND REASON.	-	1	20			
. TYPE CHUTE RELEASE DEVICE			SS RELEASE DEVICE						7.5	
			SS HELEASE DEVICE	15. WHEN WER	E RE	LEASE	DEVIC	ES 465		
THE DIFFICULTIES ENCOUNTERED WI	TH RELEA	SE DEVI	CES) IF YES					ACT	EDI	
WERE DIFFICULTIES ENCOUNTERED WI		-	IF IES, STATE DIFFI	CULTIES, WHEN EN	COUN	TERED	AND	CAUSE.		
WERE DIFFICULTIES ENCOUNTERED AFT YES NO WAS LIFE YEST INFLATED PRIOR TO ASS	ER ACTIV	ATING R	ELEASE DEVICES IS THE							
WAS LIFE VEST INFLATED PRIOR TO ACT			11 115,	STATE DIFFICULTI	ES, W	HEN E	NCOUN	TERED	AND CAUSE,	
THE THE PRIOR TO ACT	IVATING	DELEASE							100	

Æ		
1	SECTION G - DETAILED EQUIPMENT QUESTIONNAING (Continued) OF INDIVIDUAL (Last, first, middle) ANDERSON. Ronald W. 19. "INTEGRATED MARNESS SYSTEM, MODEL/TYPE 20. INTEGRATED? 21. MODIFICATIONS, IF ANY STATE REASON.	P2V-5FS
		HER
	24. IF SHOULDER HARNESS WAS USED, WAS 11. LOCKED UNLOCKED TIGHT SLACK OTHER CONDITION 25. TYPE HELMET APH-5 Nape strap 27. OTHER MODIFICATIONS AND REASON FOR THEM 29. HELMET FITTING WAS CONDUCTED BY: WEARER FLIGHT SURGEON X PARACHUTE RIGGER AVIATION EQUIPMENT OFFICER 01	ISON THER
	30. TYPE CHITE N3CR 7-12-62 31. LAST PACKING DATE 32. MODEL/TYPE BAILOUT OXYGEN 33. AUTOMATIC RIPCORD, IF NONE 34. DID AUTOMATIC RIPCORD FAILT IF YES, WHY? NO 35. WAS RIPCORD MANUAL 36. IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENCOUNTERED	
	37. DID CRUTE OPEN IMMEDIATELY? IF NO. GIVE REASON YES NO 39. OPENING SHOCK WAS: 40. BODY ATTITUDE AT OPENING 41. CONDITION OF CRUTE AFTER SEVERE	ALTITUDE THAT CHUTE OPENED FEET
	42. CHUTE OSCILLATION PRESENT: NONE SLIGHT MODERATE SEVERE 43. IF OSCILLATION WAS PRESENT, HOW WAS IT STOPPED: 44. WEATHER CONDITIONS DURING DESCENT (List in sequence) 45. TOPOGRAPHY OF LANDING SITE 46. WAS BAILOUT OXYGEN CONNECTED? 47. WAS BAILOUT OXYGEN USED? IF NOT. WHY	
	49. GIVE DIFFICULTIES ENCOUNTERED WITH BAILOUT OXYGEN AND THEIR CAN BEFORE EXIT AFTER EXIT 50. WAS CHUTE HARNESS TIGHT SNUG LOOSE NO YES NOT ATTEMPTED 52. SEAT CUSHION IF PROVIDED (Nodel/Type) NOME NOWE	F, 16077
COLUMN ACTION AC	BA. LIST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL NONE Lectures and demonstrations BB. IF ATTEMPT WAS MADE TO RELEASE PARARAPT DURING DESCENT. WAS RELEASE ACTIVATED SUCCESSFULLY! YES NO	
The second secon	THEREFOR. YES NO NO SO, WAS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF NO, GIVE REASON VES NO	S IN FIT AND GIVE REASONS
The state of the s	80. LIST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED 40. WAS MY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM, WHEN LOST, AND 81, WAS MY ITEM OF EQUIPMENT DISCARDED? IF YES AND REASON FOR DISCARD. 10. NO YES NO YES	YES, STATE LITEM, WHEN DISCAR

	NDIVIDUAL (Last, first, middle)	Liberioi Liii	ROM A/C AND SU		MODEL A/C						
	ERSON, Ronald W.	P2V-5F3									
_	S.SUSPECTED. E-ESTABLISHED			REMARKS							
E	1. EJECTION - Attempted										
-	2 Accomplished										
-	3 Through canopy										
s NO	The same and a same and a same	IF YES, EXPLAIN	DIFFICULTIES								
3 1 110	4 Prior to										
+	5 During										
+	6 Subsequent to										
****	7. Give type and model of seat used										
****	8. BAILOUT - Attempted										
	- Accomplished			-/	11. AIRSPEED						
ALTITU	DE AT TIME OF EXIT (feet)			A/C AT EXIT OR IMPACT							
OVE SE	A LEVEL ABOVE TOPOGRAPHY			light nose u	16. FLAPS						
COLLI	SION OF A/C WITH 13. CONTROLLED?		X ON OFF	X UP DOWN	FULL X UP PART						
	ROUND WATER X YES NO	TATE 19.									
CANOP	PY POSITION AT EXIT OR IMPACT 18. SEA S	TATE	88 *	°r SEC							
□ °	PEN CLOSED JETTISONED		IF NO STATE REASON F	OR CHOICE.							
AIL OU			IF NO STATE REASON .	20.000000							
OR	None YES	NO STATE NA	ATURE OF DIFFICULTY								
SION	26. DIFFICULTIES WITH THIS EXIT WERE IN IN IN IN EXIT		arone or our record								
WITH	MENCHING	ING									
WATER	28. BODY POSITION DURING EXIT										
. LIST	other factors not indicated above which affect al injuries on impact with										
ata	other factors not indicated above which affect	ground.	or this accident.	Prepare a detailed	i narrative account of the						
ata	OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECT	ground.			narrative account of the tiem number (e.g., H30,						
ata	other factors not indicated above which affect al injuries on impact with al factors: Check factors below which a factors checked below and a H31, etc.)	ground.	MAINTAINING	BODY TEMPERATURE:	narrative account of the term number (e.g., H30,						
ata	other factors not indicated above which affect al injuries on impact with al factors: Check factors below which a factors checked below and a	ground.	MAINTAINING 50. Ite	BODY TEMPERATURE:	narrative account of the tiem number (e.g., H30,						
ata	other factors not indicated above which affect al injuries on impact with al factors: Check factors below which a factors checked below and a H31, etc.)	ground.	MAINTAINING 50. Ite	BODY TEMPERATURE:	narrative account of the litem number (e.g., H30,						
ata	other factors not indicated above which affect al injuries on impact with al factors: Check factors below which a factors checked below and a H31, etc.) NICATIONS: 30. Communicated position prior to mishap	ground.	MAINTAINING 50. Ite	ms used as shelter ms used as clothing	narrative account of the litem number (e.g., H30,						
ata	other factors not indicated above which affect al injuries on impact with al factors: Check factors below which a factors checked below and a H31, etc.) NICATIONS: 30. Communicated position prior to mishap 31. Witnesses at scene	ground.	50. Ite 51. Ite 52. Fir 53. OT	BODY TEMPERATURE: ms used as shelter ms used as clothing e HER:	narrative account of the litem number (e.g., H30,						
ata	al injuries on impact with AL FACTORS: Check factors below which a factors checked below and a Hi31, etc.) NICATIONS: 30. Communicated position prior to mishap 31. Witnesses at scene 32. Electronic signal devices	ground.	MAINTAINING 50. Ites 51. Ites 52. Fit 53. OT ENVIRONMEN	BODY TEMPERATURE: ms used as shelter ms used as clothing e HER: ral HAZAROS:							
ata	al injuries on impact with AL FACTORS: Check factors below which a factors checked below and a Hi31, etc.) NICATIONS: 30. Communicated position prior to mishap 31. Witnesses at scene 32. Electronic signal devices 33. Visual signal devices	ground.	MAINTAINING 50. Ite 51. Ite 52. Fit 53. OT ENVIRONMEN 54. Ex	BODY TEMPERATURE: ms used as shelter ms used as clothing e HER: TAL HAZARDS:	rces						
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AUTOPSY: A-85-62

Name: ANDERSON, Ronald Williams

Race: Caucasian

Died: 7-23-62, 1044

Age:

Sex: Male

Autopsy: 7-25-62, 1100

PROLOGUE: The subject is one of the occupants of a P2V aircraft accident occurring on 23 July 1962 in the vicinity of Brunswick, Georgia. Identification is made on the basis of dental examination.

GROSS DESCRIPTION OF THE BODY:

(b) (b)

HEAD: (b) (6)

COMMENT: This portion of a human body exhibits (b) (6)

(b) (6) In addition it is severely burned.

Further pathologic examination is not warranted.

PATHOLOGIC DIAGNOSES:

(b) (6

2.

PRESIMPTIVE CAUSE OF DEATH: No single feature determined.

(b) (6)

LCDA MC USN.

SECTION C - PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, AND TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

NAME OF INDIVIDUAL (Last, first, siddle) CAWTHON, James V. MODEL A/C Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8x10% plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.). PHYSIOLOGICAL: √ FACTORS SOCIO-PSYCHOLOGICAL: (Exotional stress free duty sources) 1. Physically incapacitated in flight 29. Expeditings/Delays 2. "G" forces 30. Weather 3. Environmental stress - External 31. Mechanical Problems 4. - Internal 32. Social and working relationships 5. Dysbarism/explosive decompression 33. Personal comfort 6. Diet 34. Regulations 7. Fatigue 35. Facilities 8. Hypoxia 9. Related illness 36. Navigation 37. Duty assignment 10. Vertigo/Disorientation/Illusions 38. Personality traits 11. Hyperventilation NON-STRESS FACTORS: 12. Drugs 39. Faulty attention 13. Physical state 14. OTHER: 40. Poor judgement HUMAN ENGINEERING AND DESIGN: 41. Forgetfulness 15. Personal equipment 42. OTHER SOCIO-PSYCHOLOGICAL FACTORS 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference TRAINING FACTORS: 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-daty sources) 43. Physiological training 44. Emergency Procedures training 21. Pregnancy 22. Illness or death 45. Survival and rescue training 46. Refresher training 23. Arguments 47. Transition training 24. Elated/Depressed state 48. OTHER: 25. Personal habits - Drinking 26. - Sex 27. - Gambling 28. - Debts SECTION D - AIR CREW DATA (fill in phere applicable) 1. Plight time past 30 days 4.9 2. Flight time last 24 hours 7. Total time in model 3. Number of flights in last 24 hours 2. 1 8. Number of days grounded last month, give reason 4. Time at controls this flight None 2. 1 9. Number of and dates of previous accidents 5. Number of hours duty last 24 hours 3.5 6. Total flight time 334.8 SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSES (As condensed from Port I, Sect. D and Part VIII of the AAR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach

See Part VIII, AAR, "The Analysis."

Prepare a narrative account of damaged or failed items. Identify each item discussed (e.g., F1, F2, etc.) MODEL A/C NAME OF INDIVIDUAL (Last, first, middle) P2V-5FS CAWTHON, James V. AVAIL. UTILIZED FAILED DESCRIPTION OF DAMAGE SPECIFIC GENERAL DESCRIPTION OF YES YES NO X 1. Shoulder harness X X Not found NAF 1201 8B 2. Lap belt X 3. Inertia reel X 4. G-Sult X 5. Pressure sult-full or partial X 6. Exposure suit X Summer Flying Burned 7. Flight suit (Other than above) X X Not found X APH-5 8. Helmet X 9. Goggles/Eyeshield Field Shoes x Burned X 10. Shoes Not found X Standard Issue 11. Gloves Not found Mae West X 12. Life vest Not found MK VII X X (2) 13. Life raft 14. OTHER: Not found MK XIII X X 15. SIGNAL DEVICE - Flare (Night) Not found MK XIII X X - Flare (Day) Not found X MK XIII X - Dye marker 17. Not found X AN/GRT-3 X - Radio 18. Not found X Vest Light X - Flashlight - Mirror 20. 21. OTHER: Not found Standard Issue X 22. SURVIVAL GEAR - Knife Not found X **PSK 11** X - First ald kit 24. - Shelter - Food 25. 26. OTHER: 27. RESCUE - Vehicle 28. - Sling, Net, Stretcher 29. OTHER: SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE 2. MODIFICATIONS, IF ANY 1. MASK - MODEL OR TYPE A-13A None MODIFICATIONS, IF ANY 3. REGULATOR - MODEL OR TYPE None 7. LIST DISCREPANCIES NOTED BY PREFLIGHT CHECK 5. PREFLIGHTED BY USER? YES K NO Not usual routine in P2V 9. WAS OXYGEN IN USE AT TIME OF PRIOR TO FLIGHT TIME OF ACCIDENT ACCOT. YES X NO ____ LITERS (Liquid) 1600 P.S.I. (Gas) _ LITERS (Liquid) 1600 P.S.I. (Gas) 11. WAS ALL OXYGEN EQUIPMENT NECESSARY FOR THIS FLIGHT AVAILABLE? IF NO, LIST ITEMS AND REASON WHY. 10. IF YES, WAS SELECTOR SETTING 100% NORMAL YES 12. WAS GEYGEN MASK REMOVED AT ANY TIME IN FLIGHT! IF YES, GIVE DURATION AND REASON. NO YES IS. WHEN WERE RELEASE DEVICES ACTIVATED? 13. TYPE CHUTE RELEASE DEVICE 14. TYPE HARNESS RELEASE DEVICE 16. WERE DIFFICULTIES ENCOUNTERED WITH RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. YES NO 17. WERE DIFFICULTIES ENCOUNTERED AFTER ACTIVATING RELEASE DEVICES! IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE. 18. WAS LIFE YEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES! IF YES, WHAT DIFFICULTIES DID THIS PRODUCE! YES NO

MEDICAL OFFICER'S REPOPHAY FORM 8750-8C (5-58)				DEM! - ANGE		OPKAY REPORT S
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23. INTEGRATED HARNESS FIT						
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No	No.				35. WAS RIPCORD AC	
36. IF MANUALLY ACTIVATED S	TATE REASON AND A	MY DIFFICIATIFS ENCOUNTS	DED.		MANUAL	AUTOMATICE
	and department of	DITTOCTIES ENCOUNTE	ALU			*
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YES NO					38. ALT	TUDE THAT CHUTE OPENED
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SLI GHT MODER	ATE SEVE			41. CONDITION	F CHUTE AFTER OPE	ING
42. CHUTE OSCILLATION PRESEN	ATT	143	. IF OSCILLATION WA	S PRESENT HOW W		
NONE SLIGHT	MODERATE			FRESENT, NOW W.	IS IT STOPPED!	
44. WEATHER CONDITIONS DURIN	IG DESCENT (List	in sequence)	45. TOPOGRAP	HY OF LANDING SIT		
44. WEATHER CONDITIONS DURIN				or Entoing 311	•	
46. WAS BAILOUT OXYGEN CONNE	CTED?	47. WAS	BAILOUT OXYGEN USE	DT IF NOT. WHY		
The second secon	TER EXIT NO	Committee of the commit	ES NO			
48. WHEN WAS IT ACTIVATED?		49. GIVE DIFFICULT	IES ENCOUNTERED WIT	H BAILOUT OXYGEN	AND THEIR CAUSE.	FAW
BEFORE EXIT AF	TER EXIT					
50. WAS CHUTE HARNESS		51. WAS A SITTING	OSITION IN SLING O	BTAINED DURING DE	SCENT? IF NOT. MO	
TIGHT SNUG	LOOSE	NO Y				
52. SEAT CUSHION IF PROVIDED	(Model/Type)	53. WAS PARARAFT LA	WYARD CONNECTED TO	LIFE VEST D RING	IF NOT. WHY?	
NONE		NO YE				
54. LIST TYPE OF PARACHUTE TO					-	
		monstrations				
55. IF ATTEMPT WAS MADE TO RELEASE ACTIVATED SUCCESS	ELEASE PARARAFT D	XURING DESCENT, WAS	6. IF NO. GIVE REAS	ION		
		YES NO				
57. IF G-SUIT. EXPOSURE SUIT. THEREFOR.	FULL OR PARTIAL	PRESSURE SUIT WAS WORN.	DID IT FIT PROPERL	YT IF NOT, LIST	ISCREPANCIES IN F	IT AND GIVE REASONS
YES NO						
	A SPRING-LOADED	DISCONNECT ADAPTER? IF N	, GIVE REASON			
50. WAS G-SUIT EQUIPPED WITH						
YES NO		R SURVIVAL EQUIPMENT UTI	LIZED			
	WDARD CLOTHING O					
YES NO						
YES NO			61. WAS MY ITEM	OF EQUIPMENT DIS	CARDEDT IF YES, ST	ATE ITEM, WHEN DISCARDED.
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SE .ON H - EMERGE	NCY EXIT FROM A/C AND SURVIVAL ACTORS
CAWTHON, James V.	P2V-5FS
S E S-SUSPECTED, E-ESTABLISHED	REMARKS
1. EJECTION - Attempted	
2 Accomplished	
3 Through canopy	the state of the s
YES NO EJECTION DIFFICULTIES ENCOUNTERED IF Y	ES, EXPLAIN DIFFICULTIES
4 Prior to	
5 During	
6 Subsequent to	
7. Give type and model of seat used	
8. BAILOUT - Attempted	
- Accomplished	
ALTITUDE AT TIME OF EXIT (feet)	10. ATTITUDE OR MANEUVER OF A/C AT EXIT OR IMPACT
BOYE SEA LEVEL ABOYE TOPOGRAPHY	Wings level, slight nose up 90-110 knot
2. COLLISION OF A/C WITH 13. CONTROLLED)	ARNOWN NO OFF NUP DOWN FULL NUP PARTIAL
CANOPY POSITION AT EXIT OR IMPACT 18. SEA STATE	IP. AIR TENP. 20. WATER TEMP. 21. A/C FLOATED 22. TIME IN WATER 23. TIME IN RAFT
OPEN CLOSED JETTISONED	88 °r °r sec.
	MDED EXIT! IF NO STATE REASON FOR CHOICE.
AIL OUT	ADED EATT, IF NO STATE READON YOU CHOOSE
Tone	7. STATE NATURE OF DIFFICULTY
SION DIN DIN	
WATER 28. BODY POSITION DURING EXIT	
OR CONTROL CON	
LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT F	
Fatal injuries on impact with groundstate of the property of t	und.
s. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT F	
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AUTOPSY: A-82-62

Name: CAWTHON, James Virlyn

GROSS DESCRIPTION OF THE BODY:

Race: Caucasian

Died: 7-23-62, 1044

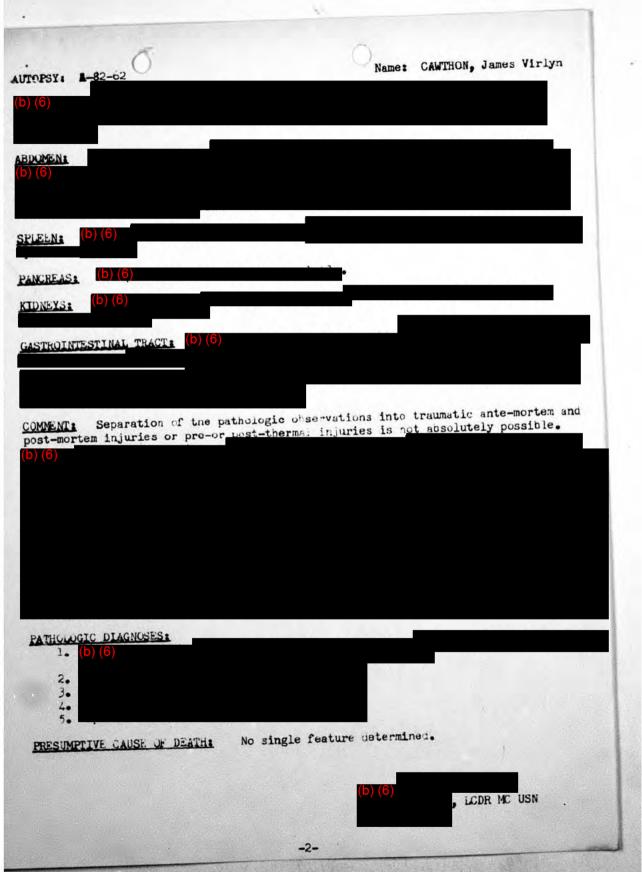
Age: 29

Sex: Male

Autopsy: 7-24-62, 1500

PROLOGUE: This body is one of several removed from a P2V aircraft accident occurring in the neighborhood of Brunswick, Georgia on 23 July 1962. Identification is established by means of dental examination.

(5) (6)			
INCISIONS: (b) (6)	•		
HEAD: (b) (6)			
HEALD:			
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MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT-Page 2

SECTION C-PHYSIOLOGICAL. HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL. . . . D TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

OPNAV REPORT 3750-7

MOSELER, Kenneth J.

MUSELEK, Kenneth J.

Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.).

Attach all sheets pertaining to these factors to this form upon completion. P2V-5FS

21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	SOCIO-PSYCHOLOGICAL: (Emotional stress from duty source 29. Expeditings/Delays 30. Weather					
3. Environmental stress - External 4 Internal 5. Dysbarism/explosive decompression 6. Diet 7. Fatigue 8. Hypoxia 9. Related illness 10. Vertigo/Disorientation/Illusions 11. Hyperventilation 12. Drugs 13. Physical state 14. OTHER: HUMAN ENGINEERING AND DESIGN: 15. Personal equipment 16. Displays and/or controls 17. Work arrangement 18. Working environment 19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	29. Expeditings/Delays 30. Weather					
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18. Working environment 19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex						
19. Habit interference 20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex						
20. OTHER: SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources) 21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex						
21. Pregnancy 22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	RAINING FACTORS:					
22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex						
22. Illness or death 23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	43. Physiological training					
23. Arguments 24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	44. Emergency Procedures training					
24. Elated/Depressed state 25. Personal habits - Drinking 26 Sex	so, Survival and rescue training					
25. Personal habits - Drinking 26 Sex	40. Refresher training					
26 Sex	47. Transition training					
	48. OTHER:					
27.						
- Gambling 28.						
ght time past 30 days ght time last 24 keins 33 0 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7						

1. Flight time past 30 days	TION D - AIR CREW	DATA (fill in where applicable)	
Flight time last 24 hours Number of flights in last 24 hours	33.0	7. Total time in model 10/2	
2. Time at controls this flight	1	Upper Respirate	Three -
5. Number of hours duty last 24 hours 6. Total flight time	Unknown 13	dates of previous accidents	
SECTION E - CONTRIBUTING FACTORS AND	1062.0	None	

SECTION E — CONTRIBUTING FACTORS AND THEIR ANALYSIS (As condensed from Part I, Sect. D and Part VIII of the ARR) NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach

See Part VIII, AAR, "The Analysis."

MOSELER, Kenn	neth	T							MODEL A/C
GENERAL DESCRIPTION OF	AV	AIL-	SPECIFIC	Tur	ILIZE	n FA	ILED		P2V-5FS
	YES	NO	SPECIFIC MODEL OR TYPE	YE	_	-	NO	DESCRIPTI	ON OF DAMAGE
1. Shoulder harness		X		\top	+	1.23	NO.	102	GOIPMENT
2. Lap belt	X		NAF 1201-8B	x	+	1.	-	No.	
3. Inertia reel		X		10	+	X	-	Not found	
I. G-Sult		X		+	+	-		-	
5. Pressure suit-full or partial		X		+	+	+	-	1	
S. Exposure suit		X		+	+	+		1	
. Flight suit (Other than above)	X		Summer Flying	x	+	-	-		
. Helmet	X		APH-5	x	+	X	-	Burned	
. Goggles/Eyeshield	X		Branch Commence	1^	+	X	6	Burned (lyin	ng beside be
Shoes	X		Field Shoes	x	-				
Gloves	X		Standard Issue	^	-	X	_	Burned	
Life vest	X		Mae West	+	X	-	_	Not found	
Life raft (2)	x		MK VII	+	X	\vdash		Not found	
OTHER:				+	X			Not found	
				+	-	-			
SIGNAL DEVICE - Flare (Night)	X		MK XIII	-	v	-	-		
- Flare (Day)	X		MK XIII	-	X	-	-	Not found	
- Dye marker	X		MK XIII	+	X		-	Not found	
- Radio	X		AN/GRT-3		X		-	Not found	
- Flashlight	X	1	Vest Light		X		-	Not found	
- Mirror			Zigit .	1	X		1	Not found	
OTHER:		1		1	-		-		
SURVIVAL GEAR - Knife	X	5	tandard Issue	1	-	-	-		
- First aid kit	x	Ī	SK-2		X			Not found	
- Shelter		十	DIX-2	1	X		1	Not found	
- Food		+							
OTHER:		+			1				
RESCUE - Vehicle		+							
- Sling, Net, Stretcher		+			1				
THER:		+							
CHERLE STEEL		CE	oriou -						
1. MASK - MODEL OR TYPE	2. MODII	ICATI	CTION G - DETAILED EQUIPMENT ONS, IF ANY	NT QUE	STIC	NNAI	RE		
A-13A		one							
3. REGULATOR - MODEL OR TYPE			ONS, IF ANY				-		
2872		on							
S. PREFLIGHTED BY USER? 6. IF	NO. WHY	NOT							
I I YES belled			l routine in P2V			7. L	IST DI	SCREPANCIES NOTED BY P	REFLIGHT CHECK
. OXYGEN PRIOR TO FLIGHT	- 45	ua		-					
SUPPLY: LITERS (Lie	uid) _16	nn	TIME OF ACCIDENT			THE		9. WAS OXYGEN I	N.USE AT TIME OF
O. IF YES, WAS SELECTOR SETTING	11. WAS	ALL	ani ani	(Liquid	1	500 r	5.1. (Carl Accol.	
MORNAL		ES	NO	HIS FLIG	HT AV	AILABLE	t tr	NO. LIST ITEMS AND REAS	ON WHY.
2. WAS OXYGEN MASK REMOVED AT ANY	TIME IN F	LICHT		-					
			TES. GIVE DURATION AND REASON				- 10		
3. TYPE CHUTE RELEASE DEVICE	14. TYP	HAD	NESS RELEASE DEVICE 15. W						
				HEN WE	E RE	LEASE D	EVICES	S ACTIVATED?	
YES NO	TH RELEA	SE DE	VICES IF YES STATE						
YES NO	No.		IF TES, STATE DIFFICULTIES,	WHEN E	NCOUN	TERED	AND C	AUSE.	
WERE DIFFICULTIES ENCOUNTERED AFT	TER ACTIV	ATIMO	DELFASE DEVICES						
TES NO			DEVICES! IF YES, STATE DE	FFICULT	IES, V	HEN EN	COUNT	TERED AND CAUSE.	
			ASE DEVICES? IF YES, WHAT DIFFICULT						

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INC OFNAY FORM 3750-8C (5-58) SECTION G - DETAIL	LED EQUIPMENT QUESTIONNAL (Cont.	OPNAY REI
THOUSE LER. Konnett 7	(Conti	
19. ISTEGRATED HARNESS SYSTEM, MODEL/TYPE 20. INTEGRA		MODEL A/C
ш		P2V-5FS
22. DID INTEGRATED HARNESS FIT PROPERLY? IF NO. LIST DISCREP	PARTIAL	neason
	ANCIES IN FIT AND GIVE REASONS THEREFOR	
23. INTEGRATED HARNESS FITTING WAS CONDUCTED BY:		
WEARER FLIGHT SURGEON PARACHUTE RIGG		
MAS USED, WAS ITI	SER AVIATION EQUIPMENT OFFICER	OTHER
LOCKED UNLOCKED TIONS		
26. LIST PRECRIPES	OTHER CONDITION	
11111-5 Nam-		
27. OTHER MODIFICATIONS AND REASON FOR THEM		
29. HEI MEY C. 170	28. DID HELMET FIT PROPERLY? IF NO.	GIVE REASON
29. HELMET FITTING WAS CONDUCTED BY:	X YES NO	
AN TYPE OF THE SURGEON PARACHUTE RIGGE	AVIATION EQUIPMENT OFFICE	
NI3CD 31. LAST PACKING DATE 32. MODEL	ATTON EQUIPMENT OFFICER	OTHER
34. DID AUTOMATIC PLOSES	33. AUTOMATIC RIPCO	ORD, IF INSTALLED (Wodel and type)
34. DID AUTOMATIC RIPCORD FAIL? IF YES, WHY?	NONE	
36. IF MANUALLY ACTION	35. WAS	RIPCORD ACTIVATION
38, IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENC	OUNTERED	MANUAL AUTOMATICS
		La control
97. DID CHUTE OPEN IMMEDIATELY? IF NO. GIVE REASON YES NO		
D. OPENING SHOCK WAS:		38. ALTITUDE THAT CHUTE OPENED
SLIGHT MODERNIA 40. BODY ATT	TTUDE AT OPENING 41 COMPLETION	
2. CHUTE OSCILLATION PRESENT:	41. CONDITION OF CHUTE	AFTER OPENING
NONE SILON	43. IF OSCILLATION WAS PRESENT. HOW WAS IT ST	
4. WEATHER CONDITIONS DURING DESCENT (List in sequence)	THE PRESENT. HOW WAS IT STO	OPP ED 7
DESCENT (List in sequence)	45. TOPOGRAPHY OF LANDING SITE	
. WAS BAILOUT OXYGEN CONNECTED?		
BEFORE EXIT AFTER EXIT 47.	WAS BAILOUT OXYGEN USED? IF NOT, WHY	
WHEN WAS IT ACTIVATION	YES NO	
BEFORE EXIT AFTER EXIT	LIFIES ENCOUNTERED WITH BAILOUT OXYGEN AND THE IS	
WAS CHUTE HARNESS	THE INC.	CAUSE, IF ANY
TIGHT SNUG LOOSE 51. WAS A SITTIN	G POSITION IN SLING OBTAINED DURING DESCENT? IF	
SEAT CUSHION IF PROVIDED (Model/Type) 53, WAS PARABLET	YES NOT ATTEMPTED	NOT, WHY?
NONE	LANYARD CONNECTED TO LIFE VEST D RINGT IF NOT.	
NONE I OCTUPE TRAINING COMPLETED BY THIS INDIVIDUAL	YES TO HOT,	mit.s
IF ATTEMPT WAS MADE TO RELEASE PARARAFT DURING DESCENT. WAS		
	56. IF NO. GIVE REASON	
IF G-SUIT. EXPOSURE SUIT. FULL OR PARTIAL PRESSURE SUIT WAS WORD YES NO		
YES NO	. DID IT FIT PROPERLY? IF NOT, LIST DISCREDURA	Fe in our
	- South MC	THE FIT AND GIVE REASONS
AS G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTER? IF		
TES NO	NO. GIVE REASON	
IST ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTI		
S DIV 15-	LIZED	
S ANY ITEM OF EQUIPMENT LOST? IF YES STATE ITEM. WHEN LOST. AND	T.	11
NO YES	61, WAS ANY ITEM OF EQUIPMENT DISCARDED? IF	YES, STATE LYEN
	NO YES	THEM, WHEN DISCARDED.

SECTION H - EMERGENCY	Y EXIT FROM A/C AND SURV AL FACTORS
ATE OF INDIVIDUAL (Last, first, middle)	MODEL A/C
MOSELER, Kenneth J.	P2V-5FS
S E S-SUSPECTED, E-ESTABLISHED	PEMARKS
1. EJECTION - Attempted	
2 Accomplished	
3 Through canopy	
YES NO EJECTION DIFICULTIES ENCOUNTERED IF YES.	. EXPLAIN DIFFICULTIES
4 Prior to	
5 During	
6 Subsequent to	
7. Give type and model of seat used	
8. BAILOUT - Attempted	
- Accomplished	
ALTITUDE AT TIME OF EXIT (feet)	10. ATTITUDE OR MANEUVER OF A/C AT EXIT OR IMPACT
ABOVE SEA LEVEL ABOVE TOPOGRAPHY	Wings level, slight nose up 90-110 knot
2. COLLISION OF A'C WITH 13. CONTROLLED?	14. POWER 15. WHEELS 16. FLAPS
X GROUND WATER X YES NO UNKNO	
7. CANOPY POSITION AT EXIT OR IMPACT 18. SEA STATE	19. AIR TEMP. 20. WATER TEMP. 21. A/C FLOATED 22. TIME IN WATER 23. TIME IN RAFT
OPEN CLOSED JETTI SONED	88 °F °F SEC.
BAIL OUT 24. EXIT USED 25. IS THIS THE RECOMMENDED	ED EXITT IF NO STATE REASON FOR CHOICE.
OR None YES NO	
SION	STATE NATURE OF DIFFICULTY
WITH IN REACHING OPENING EXITING	
WATER 28. BODY POSITION DURING EXIT	
OR	
atal injuries on impact with ground	d.
e. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT FROM atal injuries on impact with ground URVIVAL FACTORS: Check factors below which are appropriate factors checked below and attach to the	
*atal injuries on impact with ground URVIVAL FACTORS: Check factors below which are appropriate factors checked below and attach to the H31, etc.)	d.
atal injuries on impact with ground URVIVAL FACTORS: Check factors below which are appropri factors checked below and attach to th OMMUNICATIONS:	d. iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE:
atal injuries on impact with ground URVIVAL FACTORS: Check factors below which are appropri factors checked below and attach to th H31, etc.) OMMUNICATIONS: 30. Communicated position prior to mishap	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter
atal injuries on impact with ground atal injuries on impact with ground URVIVAL FACTORS: Check factors below which are appropri factors checked below and attach to th DIMENNICATIONS: 30. Communicated position prior to mishap 31. Witnesses at scene	d. iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE:
atal injuries on impact with ground atal injuries on impact with ground urvival factors: Check factors below which are appropri factors checked below and attach to th usual carriers 30. Communicated position prior to mishap 31. Witnesses at scene 32. Electronic signal devices	d. iate for this accident. Prepare s detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing
atal injuries on impact with ground atal ground atal injuries on impact with ground atal ground atal injuries on impact with ground atal injuries on impact which are appropring feators checked below and attach to the highly etc.) atal ground atal injuries on impact with ground atal injuries on impact which are appropring feators checked below which are appropring feators checked below and attach to the highly etc.) atal injuries on impact with ground atal injuries on injurie	iate for this accident. Prepare s detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER:
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S. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT FROM "atal injuries on impact with ground "atal injuries on impact which are appropriated and attach to the state of the state o	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as sholter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive
S. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT FROM "atal injuries on impact with ground "atal injuries on impact which are appropriated and attach to the state of the state o	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom
S. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT FROM "atal injuries on impact with ground "atal injuries on impact which are appropriated and attach to the state of the state o	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom 62. Rationing, activities, and group coordination
S. LIST OTHER FACTORS NOT INDICATED ABOVE WHICH AFFECTED EXIT FROM "atal injuries on impact with ground "atal injuries on impact which are appropriated to the second and attach to the state of the second and attach to the second and attach t	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom 62. Rationing, activities, and group coordination 63. OTHER:
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Catal injuries on impact with ground attach injuries on impact with ground attach injuries on impact with ground attach injuries on impact with ground fectors checked below and attach to the hill, etc.) OMMUNICATIONS: 30. Communicated position prior to mishap 31. Witnesses at scene 32. Electronic signal devices 33. Visual signal devices 34. Auditory signal devices 35. OTHER: **RAVEL:** 36. LAND 37. WATER **HELTER:** 38. Life raft 39. Parachute 40. A/C structure 41. Natural shelter 42. Man-made shelter 43. OTHER: **MATER SOURCE:** 44. Desalter kit, seawater or solar still 45. Rain, dew, snow, ice, etc. 46. Processed beverages	iate for this accident. Prepare a detailed narrative account of the his form. Identify each item discussed by item number (e.g., H30, MAINTAINING BODY TEMPERATURE: 50. Items used as shelter 51. Items used as clothing 52. Fire 53. OTHER: ENVIRONMENTAL HAZARDS: 54. Exposure to natural forces 55. Exposure to dangerous animals and plants 56. Unfriendly native population 57. OTHER: MORALE: 58. Isolation 59. Psychological shock 60. Lack of motivation to survive 61. Boredom 62. Rationing, activities, and group coordination 63. OTHER: FOOD SOURCE: 64. Prepared survival rations 65. Animals/plants
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MOSE	LER	. K	eni	net	a J.														P	ev-	5F	S	
2. AGE	3. HEIG	TE SUBSTITUTE OF THE PROPERTY			GHT	A CONTRACTOR				ACING AT T	IME OF	ACCIDE	NT								6	.INJUR	Y C006
22 LUNCONSC	200000	INCHE	S	16)	1	lig	ht de		TTOWN IN	niniee.					_						A	
		ON	. [Ton	IER				1 "	NTERNAL IN	JUMES	(Non-)	fatel	cases)									
		_	_	_	tve tta	•)	-	-	1	10. FACI	AL INJU	RIES ((0. e. c.	,		T	1. 18	TRA-0	RAL IN	JURIE	.5	_	_
HEAD		NOR		SERIO	ous	CRI	TICAL	X FAT	TAL	Cha	Charring												
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	a	GHT					LEFT				X	II GHT						χļ	DT .				
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MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 6

OPNAY REPORT 3750-7

AUTOPSY: A-83-62 Name: MOSELER, Kenneth Joseph Age: Sex: Male Race: Caucasian Died: 7-23-62, 1044 Autopsy: 7-25-62, 0930 CLINICAL SUMMARY: This person was a crew member of the Navy P2V patrol bomber which crashed 7-23-62. (See 1st para. Autopsy 89-62 for further details of that crash). EXTERNAL EXAMINATION: (b) (6) SUMMARY OF GROSS FINDINGS: Injuries, multiple, extreme: GROSS PATHOLOGIC DIAGNOSES: 1. 2. AUSE OF DEATH: Injuries, multiple, extreme (Aircraft accident). LADA MC USI

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT-Page 2

OPNAV FORM 3750-8A (REV. 5-58)

OPNAV REPORT 3750-7

SECTION C-PHYSIOLOGICAL, HUMAN ENGINEERING, DESIGN, SOCIO-PSYCHOLOGICAL, D TRAINING FACTORS WHICH CONTRIBUTED IN SOME DEGREE TO THIS A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT

NAME OF INDIVIDUAL (Last, first, middle)

WILLIS, Harry C.

MODEL A/C

P2V-5FS

Check E-Established, S-Suspected, or P-Present for each factor selected. Additional 8X10½ plain sheets will be used for the supporting account of items checked below. Identify each statement with the factor and section identification (e.g., C1, C2, etc.). Attach all sheets pertaining to these factors to this form upon completion.

E	5	P	√ FACTORS	E	S	P	√ FACTORS
			PHYSIOLOGICAL:				SOCIO-PSYCHOLOGICAL! (Emotional stress from duty sources
			1. Physically incapacitated in flight				29. Expeditings/Delays
			2. "G" forces				30. Weather
			3. Environmental stress - External				31. Mechanical Problems
			4 Internal				32. Social and working relationships
			Dysbarism/explosive decompression				33. Personal comfort
1			6. Diet				34. Regulations
			7. Fatigue				35. Facilities
			8. Hypoxia				36. Navigation
			9. Related illness				37. Duty assignment
			Vertigo/Disorientation/Illusions				38. Personality traits
			11. Hyperventilation				NON-STRESS FACTORS:
1			12. Drugs				39. Faulty attention
			13. Physical state				40. Poor judgement
			14. OTHER:				41. Forgetfülness
			HUMAN ENGINEERING AND DESIGN:				42. OTHER SOCIO-PSYCHOLOGICAL FACTORS
			15. Personal equipment				
1			16. Displays and/or controls				
			17. Work arrangement				
			18. Working environment				
			19. Habit interference				TRAINING FACTORS:
			20. OTHER:				43. Physiological training
			SOCIO-PSYCHOLOGICAL: (Emotional stress from non-duty sources)				44. Emergency Procedures training
			21. Pregnancy				45. Survival and rescue training
			22. Illness or death				46. Refresher training
			23. Arguments				47. Transition training
			24. Elated/Depressed state				48. OTHER:
			25. Personal habits - Drinking				
			26 Sex				
			27 Gambling		1		
1			28 Debts			1	

SEC	TION D - AIR CREW	DATA (fill in where applicable)
1. Flight time past 30 days	8.1	7. Total time in model 8.1
2. Flight time last 24 hours	2.1	8. Number of days grounded last month, give reason
3. Number of flights in last 24 hours	1	None
4. Time at controls this flight	Unknown	
5. Number of hours duty last 24 hours	3.5	
6. Total flight time	8.1	None

SECTION E - CONTRIBUTING FACTORS AND THEIR ANALYSIS (As condensed from Part I, Sect. D and Part VIII of the ARR)

NOTE: Fill in this section only on that set of forms prepared for FIRST individual listed in Section A, i.e. 15(a). Attach additional sheets as necessary.

See Part VIII, AAR, "The Analysis".

MEDICAL OFFICER'S REPORT OF A/C ACCIDENT, INCIDENT, OR GROUND ACCIDENT - PAGE 3 OPNAY REPORT 3750-7 OPNAV FORM 3750-8B (5-58) SECTION F - SAFETY, PERSONAL, AND SURVIVAL EQ. MENT
Prepare a narrative account of damaged or failed items. Identify each item discussed (e.g., F1, F2, etc.) NAME OF INDIVIDUAL (Last, first, middle) P2V-5FS WILLIS, Harry C. AVAIL-UTILIZED | FAILED DESCRIPTION OF DAMAGE SPECIFIC MODEL OR TYPE GENERAL DESCRIPTION OF YES NO YES NO YES NO X 1. Shoulder harness X NAF 1201-8B X X Not found 2. Lap belt X 3. Inertia reel X 4. G-Sult X 5. Pressure sult-full or partial X 6. Exposure suit X Summer Flying X Burned 7. Flight suit (Other than above) X X X Not found 8. Helmet APH-5 X 9. Goggles/Eyeshield X X Field Shoes X Burned 10. Shoes X X Not found Standard Issue 11. Gloves X X Not found Mae West 12. Life vest X X MK VII Not found 13. Life raft 14. OTHER: Not found 15. SIGNAL DEVICE - Flare (Night) X MK XIII X Not found MK XIII X X - Flare (Day) 16. MK XIII X Not found X - Dye marker X AN/GRT-3 X Not found 18. - Radio X Not found X Vest Light 19. - Flashlight 20. - Mirror 21. OTHER: Not found X X Standard Issue 22. SURVIVAL GEAR - Knife X Not found X PSK 11 - First aid kit 24. - Shelter - Food 25. 26. OTHER: 27. RESCUE - Vehicle - Sling, Net, Stretcher 28. 29. OTHER: SECTION G - DETAILED EQUIPMENT QUESTIONNAIRE 1. MASK - MODEL OR TYPE 2. MODIFICATIONS, IF ANY A-13A None 4. MODIFICATIONS, IF ANY 3. REGULATOR - MODEL OR TYPE EQUIPMENT None 2872 S. PREFLIGHTED BY USER?
YES X NO 7. LIST DISCREPANCIES NOTED BY PREFLIGHT CHECK 6. IF NO. WHY NOT Not usual routine in P2V 9. WAS OXYGEN IN USE AT TIME OF TIME OF ACCIDENT PRIOR TO FLIGHT DXYGEN ACCOT. YES X NO ____ LITERS (Liquid) 1600 P.S.I. (Gas) _____ LITERS (Liquid) 1600 P.S.I. (Gas) 11. WAS ALL DAYGEN EQUIPMENT NECESSARY FOR THIS FLIGHT AVAILABLE! IF NO, LIST ITEMS AND REASON WHY. 10. IF YES, WAS SELECTOR SETTING 100% NORMAL YES NO 12. WAS DAYGEN WASK REMOVED AT ANY TIME IN FLIGHT? IF YES, GIVE DURATION AND REASON. NO YES

& U. S. GOVERNMENT PRINTING OFFICE : 1960-876364

13. TYPE CHUTE RELEASE DEVICE

YES NO

YES NO

YES NO

DEVICES

14. TYPE HARNESS RELEASE DEVICE

18. WAS LIFE VEST INFLATED PRIOR TO ACTIVATING RELEASE DEVICES? IF YES, WHAT DIFFICULTIES OID THIS PRODUCE?

16. WERE DIFFICULTIES ENCOUNTERED WITH RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE.

17. WERE DIFFICULTIES ENCOUNTERED AFTER ACTIVATING RELEASE DEVICES? IF YES, STATE DIFFICULTIES, WHEN ENCOUNTERED AND CAUSE.

(Continued on OPNAV FORM 3750-8C)

15. WHEN WERE RELEASE DEVICES ACTIVATED?

NO YES NO YES NO YES PARTIAL NO YES 13. INTEGRATED HARNESS FITT PROPERLY? IF NO. LIST DISCREPANCIES IN FIT AND GIVE RIP WEARER PLIGHT SURGEON PARAGRUTE RIGGER AVIATION 4. IF SHOULDER HARNESS WAS USED, WAS IT: LOCKED UNLOCKED TIGHT SLACK OTHER CONDITIONS APH-5 Nape strap 7. OTHER MODIFICATIONS AND REASON FOR THEM WEARER FLIGHT SURGEON PARACRUTE RIGGER AVIATION EXAMPLES OF THEM TYPE CHUTE 31. LAST PACKING DATE 32. MODEL/TYPE DAILOUT OXYGEN NO IF MANUALLY ACTIVATED STATE REASON AND ANY DIFFICULTIES ENCOUNTERED OID CHUTE OPEN IMMEDIATELY? IF NO. GIVE REASON YES NO	MODEL A/C P2V-5FS MODIFICATIONS. IF ANY STATE REASON REASONS THEREFOR DECULIPMENT OFFICER OTHER OTHER OTHER OTHER OTHER OTHER S3. AUTOMATIC RIPCORD. IF INSTALLED (Model and type) NONE S5. WAS RIPCORD ACTIVATION
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DID CRUTE OPEN IMMEDIATELY? IF NO. GIVE REASON YES NO	l luman
DID CRUTE OPEN IMMEDIATELY? IF NO. GIVE REASON YES NO	MARUAL AUTOMOTION
J 165 NO	AUTOMATIC?
J 165 NO	
	10 11 11
OPENING SHOCK WAS:	38. ALTITUDE THAT CHUTE OPENED
SLIGHT MODERATE SEVERE 40. BODY ATTITUDE AT OPENING	41. CONDITION OF CHUTE AFTER OPENING
CHUTE OSCILLATION PRESENT:	
NONE SLIGHT MODERATE SEVERE 43. IF OSCILLATION WAS	S PRESENT. HOW WAS IT STOPPED?
EATHER CONDITIONS DURING DESCENT (Liet to an	
10FOGRAPHY	Y OF LANDING SITE
AS BAILOUT OXYGEN CONNECTED?	
BEFORE EXIT AFTER EXIT NO N.A. 47. WAS BAILOUT OXYGEN USED?	7 IF NOT, WHY
49. GIVE DIFFICULTIES DISSU	
TIGHT SING CONT.	74 Date
NONE SS. WAS PARAPAT LANYARD CONNECTED TO LI	IFF WEST
ST TYPE OF PARACHUTE TRAINING COMPLETED BY THIS INDIVIDUAL	TEST D RINGT IF NOT. WHY?
Lectures and a	
ONE Lectures and demonstrations ATTEMPT WAS MADE TO RELEASE PARAMAFT DURING DESCENT. WAS 56. IF NO. GIVE BEACON.	
G-SUIT. EXPOSURE SUIT. FULL OR PARTIAL RESCAUSE	
G-SUIT, EXPOSURE SUIT, FULL OR PARTIAL PRESSURE SUIT WAS WORN, DID IT FIT PROPERLY? IS NO	IF NOT, LIST DISCREPANCING IN
U ***	MICIES IN FIT AND GIVE REASONS
G-SUIT EQUIPPED WITH A SPRING-LOADED DISCONNECT ADAPTERT IF NO. GIVE REASON	
ALL ITEMS OF NON-STANDARD CLOTHING OR SURVIVAL EQUIPMENT UTILIZED	
NY ITEM OF EQUIPMENT LOST! IF YES STATE ITEM, WHEN LOST, AND 61. WAS MY ITEM OF	
YES 61. WAS MY ITEM OF E	EQUIPMENT DISCARDEDT IF YES, STATE ITEM, WHEN DISCARDED,
□ NO □,	YES

	MERGENCY EXIT FROM A/C AND SURV. AL FACTORS
NA; E OF INDIVIDUAL (Last, first, middle)	MODEL A/C
WILLIS, Harry C.	P2V-5FS
S E S-SUSPECTED, E-ESTABLISHED	PEMAPKS
1. EJECTION - Attempted	
2 Accomplished	
3 Through canopy	
YES NO EJECTION DIFICULTIES ENCOUNTERED	IF YES, EXPLAIN DIFFICULTIES
4 Prior to	
5 During	
6 Subsequent to	
7. Give type and model of seat used	
8. BAILOUT - Attempted	
- Accomplished	
. ALTITUDE AT TIME OF EXIT (feet)	10. ATTITUDE OR MANEUVER OF A/C AT EXIT OR IMPACT 11. AIRSPEED
ABOVE SEA LEVEL ABOVE TOPOGRAPHY	Wings level, slight nose up 90-110 km
2. COLLISION OF A/C WITH 13. CONTROLLED?	14. POWER 15. WHEELS 16. FLAPS
X GROUND WATER X YES NO	UNKNOWN X ON OFF X UP DOWN FULL X UP PARTE
7. CANOPY POSITION AT EXIT OR IMPACT 18. SEA	
OPEN CLOSED JETTISONED	80
BAIL OUT 24. EXIT USED 25. IS THIS THE	RECOMMENDED EXITY IF NO STATE REASON FOR CHOICE.
OR None YES COLLI	NO NO
SION 26. DIFFICULTIES WITH THIS EXIT WERE	27. STATE NATURE OF DIFFICULTY
WITH REACHING OPENING EXIT	ING
WATER 28. BODY POSITION DURING EXIT	
GROUND	
atat injuries on impact with	ground.
SURVIVAL FACTORS: Check factors below which are	e appropriate for this accident. Prepare a detailed narrative account of the
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AUTOPSY: A-81-62

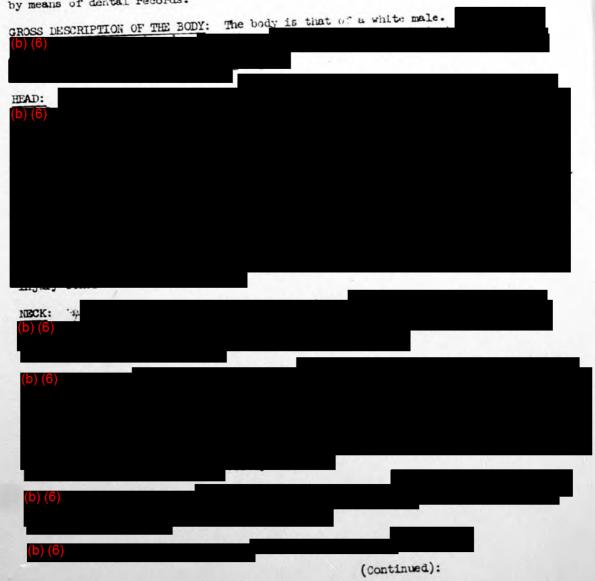
Name: WILLIS, Harry Charles

Pace: Caucasian Died: 7-23-1044

Age: 24

Sex: Male Autopsy: 7-24-62, 1300

PREFACE: This body is one of seven recovered in connection with a P2V aircraft accident in the region of Brunswick, Georgia or. 23 July 1962. Identification is by means of dental records.



Name: WILLIS, Harry Charles AUTOPSY: A-81-62 INCISION: The usual Y-shaped thoracoabdominal incision is utilized. CHEST: HEART: LUNGS: LIVER: SPIEEN: KIDNEYS: (b) (6) PANCREAS: (b) (6) CASTROINTESTINAL TRACT: (b) (6) - 2 - (Cont'd):

AUTOPSY: A-81-62 Name: WILLIS, Harry Charles COMMENT: Separation of the injuries seen in this individual into ante-mortem versus post-mortem, or into ante-thermal versus post-thermal periods with any degree of certainity is impossible. PATHOLOGIC DIAGNOSES: 2.

PRESUMPTIVE CAUSE OF DEATH: No single feature determined.

F-29 - Statement concerning PEARSON, J. H., AN, (b) (6)

Immediately after the accident, rescue operations began with the S.A.R. helicopter launched with the Flight Surgeon and two members of the crash crew. Unable to land near the crash, he set down in a small clearing approximately one-quarter mile from the crash scene. Both members of the crash crew were dressed in full fire-fighting equipment consisting of gloves, coat, pants and boots. All three rapidly became separated in trying to proceed as fast as possible through extremely heavy underbrush. The Flight Surgeon and one fire fighter arrived at the crash scene but due to numerous personnel who had arrived by trucks milling around it was some time after the crash that the other member of the fire-fighting team was missing. Immediate steps were taken to send out search parties and bring the S.A.R. helicopter back into service. Two hours later the missing man was found dead lying on the ground face down. He was still wearing the firefighting coat, pants and boots. He evidently had lost his gloves and helmet.

The body was found approximately 300 yards west of the scene and about 500 yards from his original starting point. From other witnesses' statements was noted that once entering the underbrush all sense of direction was lost and he could have easily traveled in circles in trying to reach the crash.

He was transported to USNH, Jacksonville, Florida where an autopsy was performed. The gross pathological findings indicated 3° burns to back and feet, heat exhaustion and pulmonary edema from possible inhalation of smoke or hot air.

The autopsy gives credence to the fact that he at one time did reach the area of the crash but because of the extreme heat ran away and died from a combination of burns from the crash and heat exhaustion.

This enclosure is included to suggest that members of crash crews should remove all heavy clothing when not actively engaging in rescue or fire-fighting operations. Because of the heavy insulation and extremely limited ventilation, heat exhaustion can occur in a very short time when outside temperatures are in the high 80's or low 90's.

A separate investigation is being conducted by NAS, Glynco, Georgia, and this brief resume is submitted only in the interest of safety information.

THE TAPE

The tape recording that was made, as a matter of standard practice, by the controlling GCA unit, is a unique article of evidence in that an apparently stuck microphone button in the cockpit of the aircraft caused sounds in the cockpit to be transmitted over UHF and therefore recorded. The GCA approach was the fourth for the aircraft and all approaches seemed to be normal in all respects. The GCA unit used a student controller. The aircraft flight evolutions during the fourth approach were apparently smooth and well coordinated members of the Aircraft Accident Board identified the voice of the pilot acknowledging for GCA transmissions during the approach as that of LT McHUGH. "Spangle 12" (the tactical voice call of the aircraft) came down the glide path holding just slightly above the glide path two and one half miles from the GCA touchdown point which is located 500 feet from the end of the runway. By one mile "Spangle 12" was on the glide path and receiving small heading corrections utilizing no gyro approach procedures. At one quarter mile the GCA controller advised the pilot that he was on glide path at precision minimums and should take over visually. At this point the runway centerline was reported straight ahead. The aircraft was observed, on radar, to level off as it passed over the end of the runway. "Spangle 12" was advised to climb straight ahead to 500 feet upon completion of the low pass. Twenty-four seconds after passing over GCA touchdown point the voice of LT BROUGHTON as identified by

members of the board started to roger for the last transmission of the GCA Controller. From this point on the mike button remained depressed and cockpit sounds were transmitted. LT BROUGHTON's transmission was interrupted. Four seconds later the sound of ANDERSON's voice, remote from the transmitting microphone and identified by enlisted personnel familiar with his voice, shouted "Feather it! Feather it! Feather." Two seconds after the third "Feather" there was a noticeable decrease in the engine noise being transmitted. Six seconds later there was a sound similar to a muffled explosion transmitted, seven seconds later a crunching sound, one second later LT BROUGHTON's voice transmitted "were going in, this is Spangle 12", and 21 seconds later what appears to be the final impact sound, was transmitted from the aircraft.

MC, USN, concerning his Statement of LT (b) (6) activities following the crash of the P2V-5 west of USNAS Glynco on 23 July 1962.

Upon notification of the crash the field ambulance was dispatched to the rendevous with the helicopter. After my corpsman and I entered the helicopter, it took off and proceeded to the crash site. East of the runway it descended and picked up two members of the firefighting crew, who were clad in their asbestos suits. This necessitated leaving my corpsman in the clearing. The pilot circled the orash site several times. I could only catch brief glances from the window and I had no idea where we vere in relation to the base or as to compass points. We landed in a clearing some distance from the crash and the two firefighters disembarked. I remained in the helicopter. We circled the crash site again. I caught a glimpse of fire fighting equipment approaching the site. We desconded into a clearing which I thought to be the same clearing in which we nad previously landed.

Equipped with a Blanket Roll, First Aid Kit, and a Surgical Tray, I surveyed the clearing. I could see the smoke of the crash beyond in a clump of trees. Very shortly I was approached by a civilian truck. The three men in the truck had been employed in tapping pine trees and knew the region. They offered to drive me to the site of the crash. We proc-36ded down a confusing array of backwoods paths. We were joined by a group of Navy vehicles consisting of the ambulance I had left, a pickup wruck and other vehicles. We stopped at a very dense section of trees and organ to travel by foot. We encountered severe undergrowth. It consisted amall shrubs that grew close to the ground, larger shrubs that grew to bout eight feet in height, and thorny vines that grew up pine trees and Grough the shrubs. We proceeded by breaking down the shrubs, feeling our wey around them, or crawling under them. We also forded several small patches of mud. Once we were in this thicket we were unable to see the smoke of the crash.

Had it not been for the three civilian volunteers we could never have reached the crash site from the direction in which we started. As we were advancing we heard the fire and several small explosions.

When we arrived at the site we found a crash truck had arrived and Camed the crash site. It had temporarily extinguished a fire that would otherwise have swept down upon us.

(who had been in the convoy which we had met) and I were the first two officers on the scene. We approached the crash as closely as we could but we could see neither sign of life nor any remains. We consolidated all our forces. We were shortly joined by a number of firefighters and several officers from the base including the Executive Officer, the Operations Officer, the two Public Works Officers, the Acting Safety Officer, the Maintenance Duty Officer and others. This group and all subsequent groups approached the crash site from the opposite direction to the one that my group had used. The only sign of personal equipment which I found was one standard hardhat which was later destroyed by fire.

MC, USN, concerning his Statement of LT (b) (6) activities following the crash of the P2V-5 west of USNAS, Glynco on 23 July 1962; continued:

Page 2 of 2

My immediate efforts were in caring for the firefighters who were felled by heat exhaustion. Several of the firefighters had gone into the wreckage in a futile effort to find survivors. The fire had spread from the wreckage to the woods. There were two partially filled gas tanks that were lying 100 feet from the fire. Having exhausted our means to fight the fire we were forced to withdraw. We did send search parties into the woods to look for survivors.

When additional help and additional water arrived the fire was contained. About 1400 we were able to again approach the wreckage. The firefighters then found the six remains. It was not until 1700 that the wreckage was cool enough to remove any of the bodies.



BOARD OF INVESTIGATIONS NOTE:

reference to "east of the runway" has been determined to have been "west of the runway".

Certified to be a true copy

(b) (6)

LCOR USN

I have been in the Navy for about five months.

On 23 July 1962, I stood about my tenth four hour wheels watch at NAS Glynco, Georgia. I was on wheels watch when the plane was making overpasses. On the third overpass that I saw the plane looked like it was landing. On the pass the plane was lower than the other passes. When it was approximately 50 feet from the runway, the engines on the plane started running faster as to make another overpass. A few seconds after the engineswere run faster, the engine on the right side, or the engine on the side nearest the wheel watch, made a sound like a beckfire and black smoke came streaming out. No parts fell from the plane. Black smoke poured from the top of the engine and the right prop was cutting off and on. He tried to climb but never did until he was clear of the rumay. It kept an approximate 20 feet until the end of the runway. The engines were still running wide open but poured more smoke. The plane was off the approach end of runway 7 when it picked up altitude for about 10 seconds, then it went down. As soon as the plane dropped a flame hundreds of feet high went up.

Jul 24 1962

I have worked in control towers for about two years. I have held a senior controllers certificate since November of 1961.

I was section leader in the tower at the time of the crash, supervising the approach control and local control positions. Spangle 12 was making a CCA low pass to runway 25. Approach control had two T2V's, one making a UHF ADF approach and one making a T-4 approach. I looked up from the approach control position and saw Spangle 12 a little past mid field; his starboard jet appeared to me to be smoking. Round spurts almost like smoke rings. I grabbed a pair of binoculars to check the aircraft. When Spangle 12 was about over the numbers, west end of the runway, at about 200 feet altitude, I observed #1 engine, port side, being feathered and come to a complete stop. I immediately set off the crash phone. The left wing dipped slightly. I turned toward the crash phone and when I looked back the P2V had disappeared. About 20 to 30 seconds later I observed a ball of fire that appeared to rise about 300 feet or more. The time I first observed this was 1043(R); I saw the fireball at 1045(R).

STATEMENT OF (b) (6) ACC, (b) (6)

I am the leading chief of the GCA Unit 32 stationed at NAS Glynco, Georgia. I have worked with GCA units for about six years and as an Aviation Machinist Mate prior to that for about sixteen years. At about 1035(R) on 23 July 1962 I was in the GCA lounge trailer listening to the practice approaches of Spangle 12. I heard Spangle 12 passing over the trailer on GCA wave off with an apparent rough running reciprocating engine. The engine sounded like it was cutting in and out. On hearing the rough running engine, I jumped up and looked out the window facing west and saw that the starbcerd reciprocating engine was smoking badly (black smoke) with intermittent flames coming out from around the cowl flaps. From my vantage point I had a clear, unostructed view of the starboard side of Spangle 12. At this time the aircraft was about 3000 feet from the upwind end of runway 25 at about 200 to 250 feet of altitude. The landing gear was up at this time. Just as the aircraft approached the upwind end of runway 25 a big ball of flame came out of the top of the starboard reciprocating engine and the aircraft veered 10 degrees to the left in a very shallow bank. The aircraft then leveled its wings and descended in a shallow glide. When I saw the smoke coming from the engine I advised the tower to alert the crash crew. From the sound of the aircraft I believe Spangle 12's jet engines were not running as he passed over the GCA trailer.

I am a final approach controller attached to GCA Unit #32, at NAS Glynco, Georgia. I've been working with GCA for a bout one year and as an air controller for approximately 14 years. At about 1030 local on 23 Jul 1962, I was outside observer at the GCA unit. I had observed all of Spangle 12's previous approaches. At this time, Spangle 12 was on his fourth approach to runway 25. I had visual contact with Spangle 12 from 6 miles on final throughout the approach and wave off. I was looking out the windows on the east side of the lounge trailer and observed the P2V level off as he was notified he was over GCA touchdown and saw his wheels come up and go into the wheel wells. The wave off looked normal and he made an excellent GCA approach. He was out of my sight for about five seconds as he passed over the trailer. Chief (b) (6) said his engine sounded rough and I opened the door on the west side of the trailer and stepped out onto the first step. I noticed a slight trail of dark blue or black smoke from the starboard engine which got heavier as he proceeded down the runway. I did not notice any fire until he was about over the upwind end of runway 25. I had a clear view of the starboard side of Spangle 12 after it passed the GCA shack until it went out of sight behind the trees. As Spangle 12 passed over upwind end of runway 25, I noticed a good sized burst of flame come out of the top side of the starboard engine, Just after this the plane made a slight turn to the left with no noticeable bank. Soon after this I heard, "I'm going in, this Spangle 12" over the radio. After Spangle 12 disappeared behind the trees, I saw a big mushroom of dark orange flames (a ball of flame) and black smoke. It went well above the trees. I observed the starboard prop turning very slowly before he went out of sight. The prop did not appear to be spinning at a constant speed but seemed to be intermittently slowing down and speeding up. After hearing another P2V making a waveoff from GCA with jets, I definitely feel that Spangle 12 was not using his jets as he passed over the GCA trailer on wave off.

I am assigned to the crash crew at NAS Glynco, Georgia. I have performed duty as a member of the crash crew for about a year.

on 23 July I was standing by in an ME-5 crash truck, parked adjacent to the runway, about halfway down the way. I first noticed this P2V about 2000 feet west of the landing end of the runway. I saw that the right engine (recip) was smoking and missing. As he flew by me he looked slower than other P2V passes I had seen. From the sound the aircraft made the jets were not running as he passed by me. I could see as he flew towards me that his jet doors were closed. After he flew past me the amount of smoke increased and came out in a steady stream. After he passed the runway he turned to the left slightly and started going down. Then he seemed to stop turning and kept going down. I saw him go into the trees and then saw a big ball of smoke and flame.

On July 23, 1962, around 1030 I heard a noise that sounded like a recip motor missing. I was standing in back of an F3D on the back line at the time, approximately at the 2000 foot marker from the west end of the runway. When I looked up I saw a P2V come over the runway about 200 feet above the runway. The starboard engine was coughing black smoke. I did not see any fire in the engine. The P2V seemed to be holding the altitude that it was at until it started to turn into the port engine, west of the runway. At about the same time the starboard engine quit popping and belching smoke. After the P2V started to turn into the port engine it started to lose altitude. I kept waiting to hear the jet engine light off, but as far as I could tell they never did. As soon as the P2V started to lose altitude while in a left turn, the aircraft leveled out and then disappeared into the trees. I heard no explosion of any kind other than the noise that the motor was making going over the field.

I have been connected with naval aviation since March 26, 1962. I have been flying for nine years in private aircraft, but I am not a pilot.

STATEMENT OF (b) (6)

I was located about 3/4 of the way down the jet line, toward the west end. I heard the P2V as it approached the east end of the runway. I looked up about the time an engine coughed twice. I estimate the aircraft altitude to be 150 - 200 feet high when it was approximately 1000 feet from the approach of runway 25. After coughing two times the engine seemed to smooth out and was running fine, still holding the same altitude. On neither cough did smoke emit from the engine. The aircraft was clean in configuration all the time it was possible for me to see clearly. I noticed no increase in power of either engine. As the aircraft neared the 2000-foot markers on the west end of the runway the starboard engine started coughing rapidly; following each cough a blackish-gray cloud of smoke would come off the engine. At this time I climbed upon the tail of an F3D aircraft for a better view (approximately 12 feet high). I remember hearing the jet engines or engine trying to light off. The engines or engine (jet) may have reached idle RPM but no faster. I don't believe the power on the port engine was ever increased; however, the aircraft was veering slightly to port, with port wing slightly down. About this time he started losing altitude rapidly. I don't recall hearing the starboard engine (recip) cough or seeing it smoke at this time. I couldn't say if it was feathered or secured as the sircraft was too far away to tell. It was still clean in configuration. As the aircraft went down below the trees I could hear it for a second or two then I saw this tremendous ball of flame about 100-150 feet high (est.), followed by smoke. I heard no noise, only flame and smoke. I forgot to mention that the smoke following each cough seemed to come from the top of the engine (starboard recip), and when I saw the aircraft from the front the jet doors were closed. ENCLOSURE 15 I am a line trouble shooter. Have been in the Navy about two years and two months. I have been working around aircraft about 12 years.

I am a naval aviator with about 2200 hours flight experience, assigned to NATTC at NAS Glynco.

At approximately 1040 hours on 23 July 1962 I was preflighting an F3D aircraft for a planned local flight out of MAS Glynco, Georgia. While under the wing of the aircraft I heard a reciprocal engine malfunctioning, missing rather than a complete power failure. The aircraft sounded like it was executing a low pass over the field. AEAN BAYER, plane captain for my aircraft, called to me saying the aircraft was in trouble and was "going in". I ran to the rear of my aircraft to see the troubled aircraft. I saw a P2V aircraft at approximately 300 feet in level flight proceeding to the field boundaries on a heading of about 2500 magnetic. The aircraft held altitude and level flight for several seconds and then began to settle. There were no signs of exterior trouble, that is smoke, flying parts, trailing landing gear, etc., from the first time I saw the P2V until the last time I saw it. The P2V continued to settle holding level flight. The attitude was good for ditching allthe way until disappearing behind the line of trees to the west of the field. As the P2V settled out of sight, I heard the jet engines, sounded like F3D with both engines, turning up at maximum RPM. I do not recall hearing the jet engines operating on the P2V passed over the field. I did not hear the jet engines start up. I did not see either reciprocating engine in a feathered condition as the P2V was too far away to notice the props. It did appear that both props were turning. The P2V settled out of sight and a few seconds later a black cloud rose above the trees.

STATEMENT OF (b) (6)

I have been an air controller for twelve years. On the morning of 23 July 1962 I was working in the tower at NAS Glynco, Georgia.

on GCA frequency. His altitude appeared to be about 200 feet. About 6000 feet down the runway (25) I observed puffs of black smoke coming from the starboard side of the aircraft. The puffs continued at regular intervals and appeared from the jet on the starboard side. The aircraft appeared to climb to three or four hundred feet, turn slightly left, left wing down slightly and begin to settle. His glide was very shallow and looked as if he would recover. Crash circuit was opened and reported as a crash while the aircraft was approximately 100 feet above the tree line. He disappeared behind the tree line to the west edge of the field. A large ball of fire was observed, followed by a column of black smoke. All crash equipment was dispatched immediately.



PART VIII - THE ANALYSIS

GENERAL

The aircraft was on an authorized flight with a qualified crew and was being conducted as scheduled. The aircraft had been properly preflighted. The pilot accepted the aircraft with known discrepancies which the board feels did not affect safety of flight. The weather as reported in enclosure 17, was not a contributing factor. When the aircraft taxied at NAS Jacksonville, LT McHUGH, the PPC, was observed by line personnel to be in the right seat. All factors having a bearing on the accident will be discussed under the headings of material, personnel and supervisory.

MATERIAL

The only unincorporated Aircraft Service Changes or Engine Bulletins which could have had any bearing on the accident were: (1) ASC 861, installation of Chip Detector warning lights in the cockpit, (2) ASC 877, installation of dual 30 KVA constant frequency power. The warning lights, if installed, possibly could have given the pilot some forewarning of engine malfunction. The dual 30 KVA electrical system would have resulted in a lighter electrical load on the main DC bus at the time of the emergency, thus providing the necessary power to crank start a jet engine without taking the tire to reduce the electrical load by securing any of the inverters. The fact that the final UHF transmission of the aircraft was as strong as those received prior to the emergency precludes complete loss of electrical power to the main D.C. bus being a contributing factor.

The outstanding discrepancy concerning the propeller low pitch lights could not have been a contributing factor. The pilot was able to set both propellers at full low pitch. This is evidenced by the fact that the port prop governor was found set at full increase RPM and that the starboard propeller dome was mechanically set at the low pitch stops.

The reciprocating engines and limited accessories which were sent to O&R for disassembly and inspection were in such poor condition that the report can be accepted as completely valid only with regards to the

remaining components of the power section of the engines.

The preliminary DIR reveals no evidence of malfunction of the starboard reciprocating engine. However, reliable witnesses, being in position to observe the starboard engine, produced strong evidence of a malfunction associated with a rough running engine, smoke and fire. This evidence is not inconsistent with the preliminary DIR in that the difficulty, if confined to the ignition or induction systems, would not have been revealed in the disassembly and inspection.

Based upon witnesses' observations and the preliminary DIR indicating no significant discrepancies, it is concluded that the port engine was capable of being operated normally prior to feathering. The burned valves from the port engine as reported in the preliminary DIR subsequently have been determined by laboratry analysis to have been burned

by fire associated with the crash.

It is concluded from witnesses! statements and the path of the aircraft through the trees, which average a height of 80 feet, that the aircraft was under control of the pilot and that malfunction of control surfaces is not a contributing factor. ENCLOSURE 18

PERSONNEL

At a low altitude, the likelihood of recovering from a loss of power on one reciprocating engine, with the jet doors closed, would depend primarily on the single engine capability of the aircraft. The aircraft weight at the time of the crash, as estimated by members of the board, was 64,746 pounds. At this weight, using military rated power on the good reciprocating engine, the aircraft had single engine operating capability. At normal airspeeds for the low. pass phase of the approach and at an altitude of approximately 250 feet, a successful recovery from the loss of power of one of the reciprocating engines would have been possible. The NATOPS Manual recommends maintaining at least 141 knots CAS at 65,000 pounds for single engine climb. It is probable that the aircraft was at or very near this airspeed at the time of the emergency. Although the aircraft had the capability of single engine flight, rapid analysis and positive action would be required on the part of the pilot.

All available evidence positively establishes the fact that the port propeller was feathered. In order to determine where the propeller was feathered, an attempt was made to graphically relate sounds on the tape recording with witness observation and the aircraft's progress over the ground (enclosure 4). An average ground speed of 130 knots (217 feet per second) was assumed. This assumption is based on the fact that members of the board calculated, from the tape recording, an average ground speed of 127 knots on GCA final approach. This graphic analysis places the position of the aircraft at the time of port propeller feathering. This position precludes the likelihood of

feathering the propeller in connection with normal ditching procedures. With no evidence of port engine malfunction, the reason for feathering this engine is undetermined. The most probable reason is either incorrect analysis of the existing emergency or inadvertent pushing of the wrong feathering button. Either of these mistakes could be the result of haste on the part of the pilot in connection with the rapid action required in handling an engine emergency, involving fire, at a

With the port engine feathered and some undetermined loss of power on the starboard engine, the pilot was in dire need of power from the jet engines. If he had been following Standard Operating Procedures the jet doors would have been closed. The emergency must have been recognized and jet doors opened shortly after passing over GCA touchdown point. The MATOPS Manual states that at 140 Kts IAS, 33 seconds would be required to windmill the jets to the necessary 8% to ignite. Approximately 15 additional seconds would be required for ignition and acceleration to 100%. Therefore, immediate action upon first indication of engine malfunction would have permitted 100% power on both jets shortly after the port engine was feathered. However, the witnesses! Observations, particularly that of Captain Perkins, places the position of the aircraft at the time of obtaining jet power well beyond the point of feathering. With the aircraft losing airspeed and altitude at this point very little time was available for the jets to develop 100% power. If the aircraft was on the backside of the power curve at this point, recovery at such a low altitude would have been improbable even though the jets were approaching 100%.

The port fuel tank selector valve was found in the closed position, thus denying a source of fuel for the port jet. In order for the port

jet to be operating at a speed somewhere between idle and normal at impact, as indicated by the DIR, this valve must have been closed immediately prior to impact or as a result of impact. The same conclusion is made for the oil and hydraulic firewall shut off valve to the starboard reciprocating engine (enclosure 10) since the preliminary DIR reveals no evidence of oil starvation in this engine and it was in fact developing some power on impact. The unusual fuel system mode of operation found after the crash has therefore been determined to have been a result of either a last minute preparation for the crash or a result of impact. There are no indicat-

ions of fuel panel mismanagement.

Another possible personnel contributing factor is the use of flaps. Standard Operation Procedure call for 20 degrees of flaps on GCA final, and for low passes that flaps be raised only upon reaching an altitude of 300 feet. Time distances checks of the controller's transmissions reveal: an average ground speed of 127 knots on final approach leg. This speed is consistent with a 20 degree flap setting. The flap drive screw jacks established the fact that flaps were up at the time of impact. When the flaps were raised is undetermined. Although witnesses did not observe any changes of attitude associated with raising the flaps, it is possible that flaps were raised in small increments as the aircraft proceeded down the runway. Another possibility is that flaps were raised after the feathering of the port propeller in a desperate attempt to gain airspeed by reducing drag. Such action could have resulted in a sink rate sufficient, at this low altitude, to cause collision with the trees.

SUPERVISORY

Past Standard Operating Procedures and the NATOPS Manual do not require the use of jets other than on approaches where the weather is below 500 feet ceiling and 1 mile visibility. If the use of jets in either the idle or standby position for practice GCA low passes had been a standard operating procedure, it is quite obvious that less pressure for hasty action would have been exerted upon the pilot in this particular emergency.

COMMENTS

LT McHugh as P.P.C. and LT Broughton as student pilot were both aeronautically adapted, physically qualified and in an up-status at the time of the accident. LT Broughton was current in physical examination, low pressure chamber, night vision, and swimming. LT McHugh was current in physical examination and night vision.

There were no socio-psychological factors evident in this aircraft accident. Both pilots and plane captain had a normal intake of food and adequate rest on the day preceding the accident. The chief contributing factors in this accident are:

1. Material. It is a definite fact that difficulty was encountered with the starboard reciprocating engine. The DIR was unable to confirm a definite cause but from witnesses' statements we can conclude that it was emitting large amounts of smoke and "running rough" and two witnesses who had the best view of the right side of the aircraft state that they "saw flames coming over the top of the starboard engine." Shortly after the onset of the "rough running" starboard engine (approximately 18 seconds) the port engine was feathered and the plane was unable to maintain altitude.

2. Personnel.

(b) (5)

The plane had single engine operating capability and by advancing the throttle of the port reciprocating engine and keeping the plane in controlled flight, he could have maintained altitude. From the investigation of the board there are two principal theories concerning what caused the person or persons to make the fatal mistake of feathering the wrong engine. Either a faulty analysis was made with intentional feathering of the port engine or he used correct analysis and inadvertently pushed the wrong button. Strong evidence is given to the latter because:

A. The feathering buttons are located side by side on the throttle quadrant 3/8 inches apart. No great physical error would be required to push the wrong one in a critical situation as did exist in this emergency.

(b) (5)

From information in the DIR and witnesses' statements it is known that both jet engines were developing power before crashing. For the jets to have averted the accident the lighting sequence would have to have been started earlier because by the time 100% power was reached he was most likely on the back side of the power curve. Also there is some possibility if flaps were raised at the time of developing 100% power from the jets, the ensuing loss of altitude due to flap raising could have been the difference in hitting or missing the trees.

As a result of tremendous sudden deceleration forces and fire immediately following the crash it was impossible to correlate autopsy reports with definite positions of crewmen in the aircraft and safety and survivor equipment worn. From the wreckage distribution diagram it can be concluded that the crewmen were in the following positions immediately prior to crashing: McHugh, right or left pilot seat; Broughton, right or left pilot seat; Anderson, in his ditching station behind the 186 panel; Moseler, strapped in on one of the flight deck seats; Cawthon, radio compartment; Willis, radio compartment. The only piece of survival equipment found was an APH-5 helmet which was believed to have been thrown clear and was not involved in the fire.

RECOMMENDATIONS

- 1. That Standard Operating Procedures be revised to require jets be placed in standby or idle when practicing instrument low approaches which do not include landings.
- 2. The feathering buttons be separated by a distance of from one to two inches.
- 3. More and continued emphasis be placed on emergency procedures at the squadron level in order to maintain a high level of proficiency.

PART IX - COMMENTS

The primary cause of the accident was personnel error in that the wrong propeller was feathered. This action could have been physically accomplished by either of the pilots or the plane captain.

In addition to the above, the following contributing factors were

present in the accident.

(1) There was an undetermined malfunction of the starboard reciprocating engine which was accompanied by fire. This is significant in that it occurred at a low altitude whereby rapid action was required on the part of the pilot. Partial loss of power on this engine, in itself, was not significantally critical.

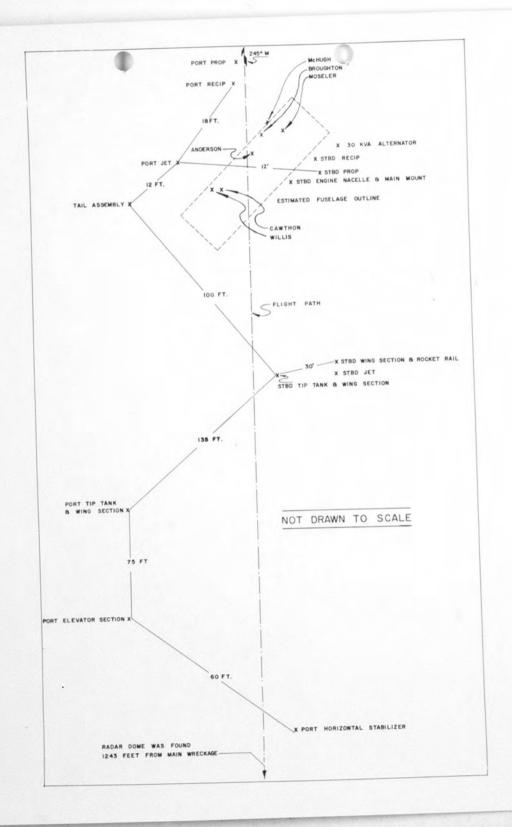
(2) The Standard Operating Procedures do not require the use of jet engines in standby or idle while making practice GCA approaches to low passes. Having jets readily available would have required less action on the part of the pilot during the emergency thereby reducing

the pressure for hasty action.

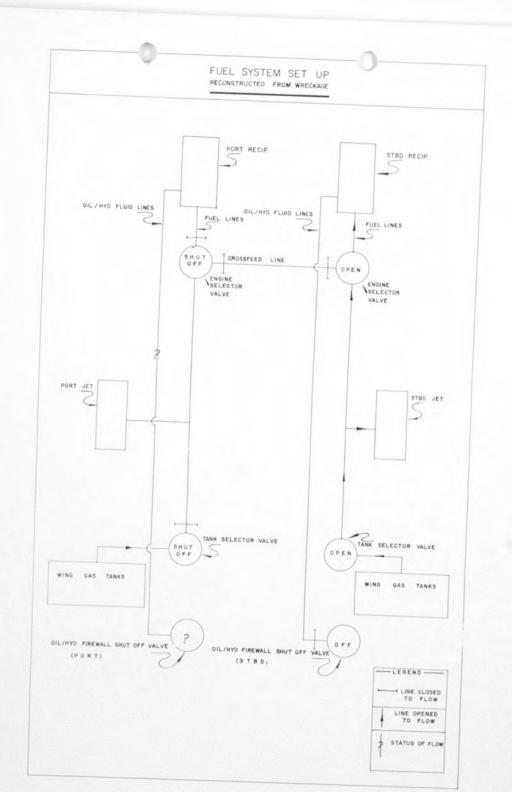
(3) The possible untimely raising of flaps just prior to collision with the trees could have been critical in itself, due to a resulting loss of altitude.

PART I - RECOMMENDATION

It is recommended that Standard Operating Procedures be revised to require jets being placed in standby or idle when practicing instrument low approaches which do not involve a landing.



20,500 10,715 FINAL IMPACT ON TAPE 14.150 (ON TAPE) SPANGLE IZ , WE'RE GOING IN" 13,941 64 IMPACT SOUND ON TAPE 12,422 57 SOUND OF MUFFLED EXPLOSION ON TAPE WITNESS OBS. PORT WING DJP HERE DEPLETION OF ENGINE NOISE ON TAPE 10.680 49 THIRD "FEATHER" FROM VOICE ON TAPE WITNESS OBS. PORT PROP FEATHERED ABOUT HERE 9500 HVERTED FOR CLARITY) 7642 ENGINE SURGE ON TAPE 7208 "SPANGLE 12 ,ROGER" ON TAPE 6200 WITHESSES DESERVE SMOKING STARBOARD RECIP. 5800 CRASH TRUCK 2000 OVER SCA TOUCHDOWN POINT ON TAPE 1500 25 "OVER END OF RUNEWAY" ON TAPE FLIGHT PATH-OCA MINIAMS "ONE QUARTER MILE" ON TAPE PEET SEC. SEQUENCE OF EVENTS FROM GCA TAPES AND WITNESS OBSERVTION.
THE & DISTANCE MEASURED FROM V4 MILE GCA MINIMUMS. NOT TO SCALE.



DATE OF ACCIDENT 23 JULY 1962

TYPE OF AIRCRAFT P2V-5FS BUNO# 1314/1 CHADRON V-16

AIR ACCIDENT REPORT NUMBER 1-6







DATE OF ACCIDENT 23 JULY 1962 LOCATION NAS GLYNCO, GEORGIA
TYPE OF AIRCRAFT P2V-5FS BUNO# 131441 SQUADRON VP-16

IR' ACCIDENT REPORT NUMBER 1-0

